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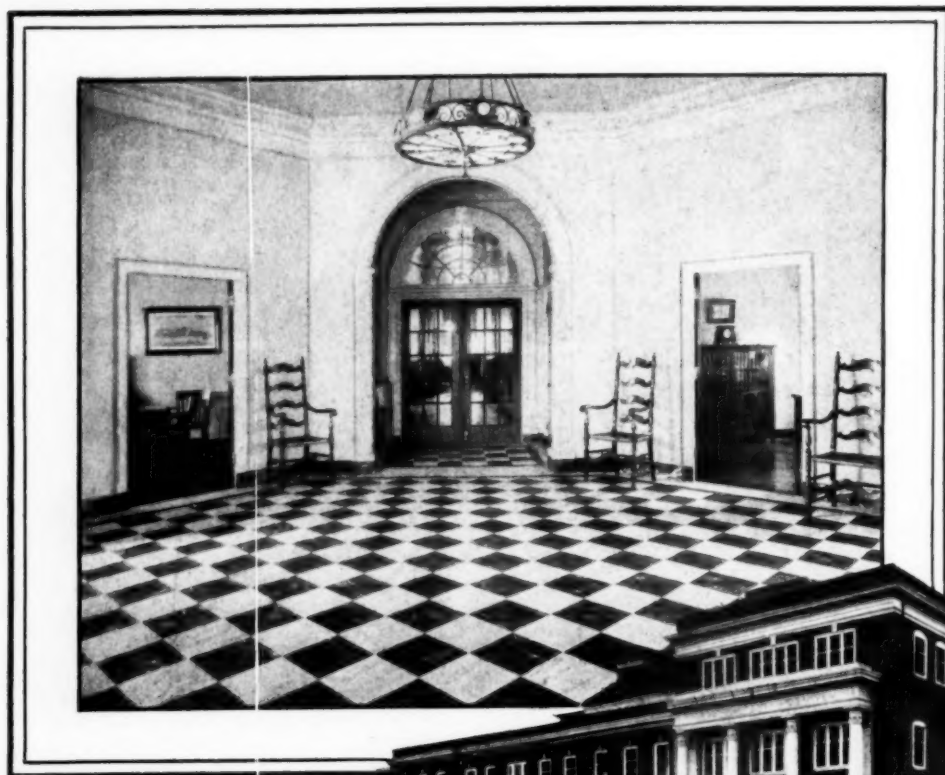


The MODERN HOSPITAL

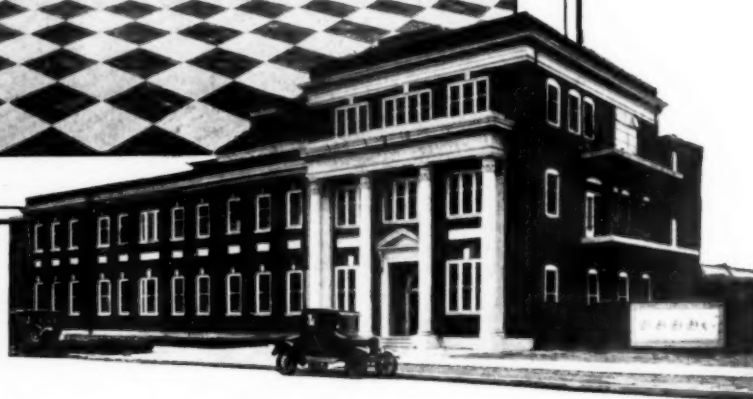
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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Building, Equipment and Administration of Hospitals, Sanatoriums and Allied Institutions, and to Their Medical, Surgical and Nursing Services

Vol. XXVI

January 1926

No. 1

DEVELOPING A COMMUNITY HEALTH PROGRAM

By H. S. Cumming, M.D., Surgeon General, U. S. Public Health Service,
Washington, D. C.

ONE principle in medicine and public health has emerged from the experience of the past decade which, to the health agency and to the hospital, is of outstanding importance: it is that sound, effective medical practice and public health work require that all health and medical activities of the community be coordinated into a comprehensive program and that the program be based on a clear understanding of the community's needs.

The hospital is becoming increasingly utilized both in private practice and in the control of disease by public health agencies. Of the 2,000,000 or more persons in the United States who at most times are disabled on account of sickness, over 500,000 are to be found in hospitals; and there is a large additional number who should be in hospitals but are not, either because the institutions are not available or because the patient cannot afford the expense of hospital service.

A variety of agencies now require the hospital for efficient service. The physician finds here the best facilities for modern scientific practice. The local medical society often needs headquarters that can be supplied only by such an institution.

Municipal and rural health departments find the hospital quite indispensable at times for the adequate control of contagious diseases. A program for combating tuberculosis necessitates the use of sanatoriums. The venereal diseases cannot be effectively dealt with without the aid of hospital

beds for special cases. The health work of the public school system requires hospital facilities, at least for brief periods, for corrective measures. Health departments, public school systems, private health agencies, general practitioners, specialists and hospitals are mutually re-enforcing agencies in a comprehensive community program; but because of the necessary dependence of these agencies upon the hospital, it is especially important that its work be related to this program.

In the development of a community program in which the hospital will assume its full and proper functions, three questions arise: (1) What diseases are most prevalent in the community? (2) in consideration of the disease situation, what are the hospital needs of the community? and (3) what agency should assume the leadership in bringing about community action for the supplying of these needs? It is appropriate that these problems be briefly

A Community's Needs

AN INTELLIGENT community, intent on bringing about the effective participation of the hospital in the control of disease, will first ascertain what diseases cause the most morbidity and disability among its people and will provide hospitals on the basis of these disease needs. Not only will the community provide beds of the kind needed and at places needed, but it will endeavor to make available facilities for convalescents and to solve the problem of providing hospital and out-patient care for people of moderate means. Such an enterprising community will strive to relate its dispensaries and clinics to its hospitals and will provide opportunity for hospital practice to all qualified physicians.

considered at the beginning of another year's work.

No accurate picture is now available of the disease and general ill health to be found in a community at any one time. No one knows what percentage of a general practitioner's time is required for any one disease—grip, diabetes, cardiac disease, tuberculosis or any other disorders. No one knows what proportion of sick persons resort to self-treatment for illnesses so serious as to require the attention of a physician or hospitalization.

Disease Situation to be Portrayed

The U. S. Public Health Service is now engaged in the collection of data that will make available a picture of the disease situation as a whole. Beginning in the autumn of 1921, this service conducted for a period of nearly two and one-half years a record of illnesses, according to cause, of a population of over 8,000 persons, by means of a house-to-house survey, followed by a series of sixteen canvasses by trained field assistants. The result of this work was supplemented by the use of school records, clinic records, reports of notifiable diseases and similar data. This service is also engaged in the collection of similar material from some fifty industrial establishments. It is hoped that in the course of the next few years statistical material may be provided that will serve as a reliable basis for the accurate determination of a community's hospital facilities.

But it is not necessary that a city or county postpone the inauguration of a community program until these data become available. In a general way, the relative incidence of the more serious diseases may be ascertained. Health authorities know that tuberculosis is much more prevalent than small-pox, that it causes 10 per cent of all deaths, and that its control requires the use of hospitals. Less is known regarding the incidence of syphilis and gonorrhea than of any other important group of diseases, but it is known that one or the other of these diseases was found in 1917 and 1918 among approximately 5 per cent of drafted men through only a superficial examination, and that the incidence for an entire year based on a thorough examination would be much higher.

Over 292,000 patients were to be found on January 1, 1923, in the mental disease hospitals of the United States, and many thousands of other persons should have been receiving treatment in such institutions but were not. There are probably 90,000 mentally handicapped children whose treatment is utterly neglected. School authorities well know that 30 to 40 per cent of children have

adenoids and diseased tonsils. While diseases of the heart are primarily disorders of old age, nearly 200,000 children are suffering from organic heart trouble; but treatment in hospitals (particularly in out-patient departments) now lacking in most communities, would prevent serious developments in many cases. There are probably 350,000 children in the country, according to an estimate based on several surveys, who are "handicapped by some limited or distorted use of muscles or skeletal members" due to rickets, bone tuberculosis, infantile paralysis, accident or other cause, a large proportion of which might be corrected in orthopedic hospitals. In many parts of the country 30 to 50 per cent of all births are attended by midwives, yet the hospitalization of maternity cases would bring about a conspicuous reduction of the infant and maternity death rate.

In some communities, a disease such as malaria or hookworm disease, may constitute the most pressing problem, while in other communities it may require little consideration. In some large cities, the venereal diseases may be more prevalent than in some small cities. Certain rural communities may be more backward in their school hygiene work than other communities, and at a particular time may require more extended hospital facilities for the removal of adenoids and diseased tonsils. The tuberculosis death rate (adjusted for age) for 1923 varied from 34.2 in Nebraska to 160.6 in Tennessee, showing clearly that in some states far greater provision must be made for the hospitalization of tuberculosis patients than in other states. The situation varies from place to place, but in every city and county a tentatively satisfactory study may be made that will reveal the main facts. No community can wisely adopt a general program of health measures until it determines which diseases are most responsible for the community's morbidity and disability.

Community's Hospital Needs Shown

With a general picture in view, inadequate though it may be, of the disease situation, the community may properly consider its need of hospital facilities.

Too frequently institutions are established to outdo a rival community or to gratify the whim of a wealthy donor, too often a department in a hospital may be added merely for the sake of institutional completeness, or badly balanced service may be due to the personal preferences of an influential chief of staff. The only sound basis for the development of facilities is a survey by an unbiased person or agency. This survey should consider, of course, such questions as the geo-

graphical position of the community, its transportation facilities, and the supply of physicians in general and special practice. In addition, it should deal with some five or six important questions of policy that may here be briefly enumerated.

First, is the total number of hospital beds in the community adequate? Various authorities agree that there should be available for local use at least five beds to every 1,000 persons, or one bed for every 200. In the entire United States at the beginning of 1923, exclusive of state, local and federal institutions for the indigent, mentally diseased and other persons, there was only one bed to every 368 persons. It appears, therefore, that the number of hospital beds in general throughout the United States is insufficient. But no community can proceed on this general fact. In some cities the number may be quite adequate, there may be even an excess of beds, and in others the shortage may be much more marked than the general shortage. In many rural districts the deficiency is striking. In one state having a total of 160 counties, only forty-one in 1925, had a hospital of any kind for community use.

A more important question is the following: Are the available beds in the community so distributed as to provide for all diseases and types of disability requiring hospitalization? Beds for contagious diseases (exclusive of tuberculosis), often necessary to the control by health departments of small-pox and other diseases, should be available in a ratio of five beds for every 2,000 population. Not all of them will usually be in use, but they are necessary for the safety of the community and the proper care of the patient. Through the establishment of communicable disease units in general hospitals, beds in such units may be used, if necessary, for general purposes; while in such emergencies as the recent epidemic of influenza, expansion of contagious units is possible. Frequently, it will be quite unnecessary for the health department to provide a separate institution for this purpose.

Beds for Tuberculous Patients

Beds for various kinds of tuberculous patients are absolutely essential to the control of this disease. There must be beds in sanatoriums and out-patient care for mild cases, and separate facilities for advanced cases. As early as in 1916, the National Tuberculosis Association recommended that general hospitals provide wards for tuberculous patients, one for each sex; and the Public Health Service has repeatedly urged that facilities for the tuberculous be provided in general hospitals, pointing out numerous specific rea-

sons for this policy. In general, there should be in a community, it is generally agreed, one bed for each death per year from tuberculosis.

Probably no community has a sufficient number of beds for syphilis and gonorrhea cases. The first hospitals of medieval Europe were established for the treatment of syphilis, yet there are inadequate provisions today for its treatment in hospitals. Although the trustees of the American Hospital Association have passed resolutions urging all general hospitals to admit venereal disease patients, a considerable proportion of institutions still discriminate against them. Out-patient care is essential, and according to the report of the committee on municipal health department practice issued in 1923 by the Public Health Service, not less than ten beds in a city of 100,000 should be available for the treatment of these diseases.

Local Conditions and Bed Capacity

The time has now come when a community may expect 25 to 40 per cent of births to be delivered in hospitals, a few cities having already exceeded this percentage. An adequate number of beds, which will vary according to local conditions, should be provided for this service.

Similarly it should be ascertained whether a sufficient number of beds is available for neuropsychiatric and pediatric cases. In no two cities, even of the same size, may the number of beds for each special need be the same. Each city and rural district must determine its peculiar needs according to its own disease situation.

It is not necessary, of course, that the municipality or county, as a political unit, establish hospitals or wards for its various needs; it is not even necessary that they be established within the community. In some instances, it will be economical and in other ways desirable to send tuberculosis, orthopedic and mental cases to state institutions. Lepers, when discovered, may be sent to a large leprosarium maintained by the Public Health Service at Carville, La., (United States Marine Hospital No. 66). But it is essential that within the community itself or within the county or state there be available an adequate number of beds for each of these various types of cases. Beds must be provided of the kind needed; a generous supply of beds in an orthopedic institution is of little use to a community in urgent need of beds for tuberculous patients.

Special attention should be given to the provision of facilities for convalescents. The shortage of hospital beds is due partially to the fact that there is a dearth of convalescent institutions. Many patients remain in hospitals who might,

with less expense to themselves, spend their convalescence in special institutions, the construction and maintenance of which cost considerably less. More frequently, perhaps, the patient receives inadequate, or no care at all during convalescence, with the result that he is not fully restored to health. There should be one convalescent bed, it is now asserted, to every ten acute beds. On this basis, there is probably not a community in the United States with an adequate number. Neither the medical profession nor the general public is yet sufficiently informed regarding the importance of the convalescent institution, but the demand for such beds will gradually increase. The forward-looking community will provide for its future needs in this respect.

A third question deals with the economics of hospital policy. Does the community provide hospital service for all of its citizens regardless of their economic status? "The one great outstanding problem before the medical profession today," according to the secretary of the American Medical Association, "is that involved in the delivery of adequate scientific medical science to all the people, rich and poor, at a cost that can be reasonably met by them in their respective stations in life." Yet again and again in medical literature, one finds the statement that, while modern scientific medical service is available to the rich and to the poor, facilities are not accessible to persons of moderate means. The time has come when the community must find some way by which both in-patient and out-patient service may be provided for such persons.

Proper Relationship of Dispensaries

Another question relates to the dispensary and out-patient department. Are the dispensaries and clinics properly related to the hospitals as out-patient departments? In order that continuity of medical care may be assured—transfer of ambulatory patients to the hospital ward for bed care, and transfer of the bed patient to the out-patient department for convalescent supervision—a unification of staff and administrative organization seems desirable. It is not necessary that all clinics be operated under the roof of the hospital, or even on the hospital grounds; an outpatient department may wisely operate certain clinics in the various parts of the city. But to an increasing extent there will be a close affiliation between dispensary and hospital. The progressive community will provide for such affiliation.

Does the community provide hospital facilities for all the physicians of the community qualified by experience to practice in a hospital? There is

doubtless, in many parts of the country, an unfortunately large proportion of such physicians to whom the hospital is not accessible. "The key to nearly everything that makes for efficient medical practice today is in the hands of the hospitals," as Dr. S. S. Goldwater so well emphasizes; and he is right when he says that the hospitals "must open wide the door of opportunity so that the entire medical profession may enter," and that "the fruits of medical progress belong of right to the many, not to the few." Fortunately the present tendency is toward the establishment of the open hospital. Of 2,412 general hospitals organized before 1920, only 66 per cent were open institutions; of those established from 1920 to 1924, the proportion increased to 83 per cent. The community earnestly desiring to provide the best service to its citizens will assure all qualified physicians access to its hospitals.

Well Equipped Hospitals Essential

The well equipped hospital is essential to the practice of modern scientific medicine, both by the general physician and the specialist. Here the family doctor may seek and find the assistance of specialists. Here are available facilities for x-ray diagnosis and treatment, and for various types of bacteriological and pathological examinations. In such an institution the physician may frequently meet his professional associates and exchange with them ideas and observations of mutual value. In some instances the hospital will afford a much needed center for the meetings of the local medical society. It is a matter of common observation that in communities where there are no hospitals, there is a conspicuous lack of surgeons and specialists. The private practitioner is dependent upon this institution for adequate service to his patients.

A final question is of particular interest to sanitarians: Is the department of health assuming its full share in the establishment and operation of hospitals? The question, at the present time, is a difficult one. Some municipal and county governments will assume considerably more responsibility and leadership in this field than others. There are unquestionably good reasons why certain health departments should maintain a contagious disease hospital: in some situations the health authorities are far better equipped to deal with certain contagious diseases than are the private practitioners of the community. Yet in many instances it may be inexpedient for the local government to occupy this field.

Present practice may throw light on the question. New York, Detroit, Cleveland, Kansas

City, Mo., Washington, Lowell, Mass., and ten other large cities in the United States of the eighty-three surveyed by the Committee on Municipal Health Department Practice, conducted, in 1921, a hospital or sanatorium with special provision for the treatment of tuberculosis. A considerably larger number maintained tuberculosis clinics. Venereal disease clinics in 1921 were conducted by forty-six large municipalities with the aid of the state and federal governments. There are some 800 in the entire country. Twenty of these large cities maintained out-patient obstetric service, and twenty-six operated prenatal clinics.

Laws have been enacted in some fifteen states, particularly in the middle west, permitting counties to tax themselves for the purpose of building community hospitals. One successful institution in Missouri is controlled by a board of trustees appointed by the county court. The staff is supplied by the county medical society, individual members of which furnish alternating service in the various specialties. Rates vary "from \$2.50 per day for the county patient, to \$6 for the choicest room and bath, such as one would have to pay \$10 or \$12 for in a metropolitan hospital."

What agency of the community, the question may now be asked, should assume the leadership in bringing all organizations together for the development of a thorough community program?

There are two reasons why the official department of health is the suitable agency to assume this leadership: first, because in the conduct of its own work it needs hospital facilities of various kinds, and second, because it is the one agency supported by all the people to which the people may look, or should be able to look, for guidance.

What the Health Department Can Do

By stimulating private effort in hospital work, by pointing out hospital needs, by educating the public regarding available hospital facilities, the department of health may become a powerful influence in the supplying of the community with adequate hospital facilities. But it should do more. It should assume the leadership in the development of a comprehensive community health program in which proper provision is made for hospitalizing the community's sick and defective. Edward A. Fitzpatrick, the winner of the recent prize essay contest conducted by THE MODERN HOSPITAL Publishing Company, is correct in stating that the official health department of the community "should have as its primary function the correlation, coordination and cooperation of all the actual and potential agencies of public health.*"

Unfortunately, in some small cities and many counties the board of health is not properly supported, and there are no health officers with the vision and ability to exercise leadership in the development of a community program. A hospital official in such a situation, may assume, if he is an able leader, one of three attitudes: he may offer very definite assistance to the health officer in bringing the various agencies of the community together for the development of a well balanced health program; he may urge upon the mayor and city council or the county commissioners the appropriation of such funds as will make possible the employment of an experienced municipal health administrator, competent to exercise this leadership; or finally, in less advanced districts, a hospital official concerned in bringing about community action may take the initiative in the creation of a central council of health and medical agencies that would elect its own officers and adopt the necessary leadership.

These, then, are the steps to be taken by an enterprising, intelligent community in bringing about the most effective participation of the hospital in the control of disease. With such a program, a community may grapple effectively with its disease enemies, reduce the mortality and morbidity rates and improve to an immeasurable extent the health and happiness of its people.

SHOULD THE LABORATORY DIRECTOR HAVE A STRAIGHT SALARY?

Should straight salaries or a percentage of the proceeds be paid to laboratory directors? In reply to this question, Clarence H. Baum, superintendent, Lake View Hospital, Danville, Ill., says that after trying out several methods of taking care of the salary of the laboratory director his hospital was convinced that a straight salary was the most satisfactory procedure for all concerned.

He believes that where the director works on a percentage basis the financial side of the work influences him to increase the charges whenever the financial position of the patient would seem to permit. He cites two instances where this practice has lost the hospital friends, as patients felt that there existed unfair discrimination. In hospitals where this arrangement was practiced the bookkeeper said that he was called upon three or four times a week to explain the laboratory charges.

Most hospitals of 100 or more beds have enough work to keep a full-time director busy and can afford to pay a minimum salary of \$5,000, as the volume of work should be such as to make the laboratory self-supporting. In small hospitals several superintendents have solved the cost problem by dividing the time of the director between several institutions or by allowing the director to take charge of the x-ray and clinical laboratories.

The ideal arrangement for financing the laboratory, in his opinion, is by means of an endowment fund so that the work essential to the patient can be done free or at a minimum cost and at the same time provide an adequate professional compensation to the director.

*"Interrelationships of Hospital and Community," THE MODERN HOSPITAL, February, 1925.

TENDENCIES IN HOSPITAL PLANNING AND CONSTRUCTION

By S. S. Goldwater, M.D., Director, Mount Sinai Hospital, New York, and President, American Conference on Hospital Service

IF AN article that recently appeared in the *Lancet* is a true reflection of British sentiment in relation to hospital planning, our friends across the water, after standing steadfastly for "sanitary towers" isolated from ward buildings by cross-ventilated passages, are now prepared abjectly to surrender the ancient and picturesque tradition that has always been recognized as a distinguishing mark of British hospital architecture.

Indeed, the swing of the pendulum seems to have carried the spokesman for Britain entirely off his feet, for not content with conceding the practicability of placing water-closets, baths, and sink rooms under the same roof with patients, the writer of the *Lancet* article selects, as America's most perfect hospital, one containing some two hundred or more windowless water-closet compartments.

The hospital that is so highly praised is one that does indeed embody many highly meritorious and skillfully planned features; nevertheless, the verdict published in the *Lancet* is one from which many Americans will dissent on principle, for although they have refused to concede the necessity of erecting costly isolated towers for plumbing fixtures and soil pipes, architects are reluctant to adopt for hospitals generally the hotel method.

Objections to the application of this hotel method to hospitals are based upon (a) the more intensive use of toilet fixtures in hospital rooms; (b) the difficulty, owing to the nature of bedpan service, of keeping floors and walls immaculately clean; (c) the cost of installing and the difficulty and expense of maintaining forced ventilation; (d) the atmospheric freshness that a wide open

window imparts, and for which even the most lavish system of mechanical ventilation is not a satisfactory substitute; (e) the superiority of broad daylight over artificial illumination for exposing dirt, and (f) the germicidal value of sunlight. Nevertheless, it seems to me that the number of architects who are willing to plan inside

toilet rooms, wholly dependent on artificial light and ventilation, is increasing, and that more hospital plans containing this debatable feature have appeared during 1925 than in any other year.

Medical men today are interested in hospital planning and construction as never before. This interest is reflected in the attitude of the American Medical Association, the largest and most powerful body of medical men in the world. The association, according to current report, is preparing to formulate, for general adoption, a law governing the erection of hospitals and infirmaries. The proposed

Noteworthy Developments

THE formulation of comprehensive standards of construction and administration for various types of convalescent homes is one of the events of the past year. This study was organized in New York, under the auspices of the public health committee of the Academy of Medicine, was participated in by institutional managers and clinicians especially interested in the care of convalescents and deals separately with surgical, medical and neurological convalescents and the needs of convalescent children.

The interest of certain foundations in the provision of small hospitals for neglected communities has led to two separate studies of very small hospitals of an inexpensive type, suitable for rural populations of limited resources.

legislation will probably deal with materials of construction, water supply, sewage disposal, room and ward arrangement, the sizes of rooms and wards, fire protection, interior finish and decoration, screening, toilet facilities, and sterilizing equipment. If the American Medical Association actually enters the field of hospital planning and construction, the medical staffs of the future will doubtless be disposed to assume a larger share of responsibility for hospital planning than has been allotted to them in the past.

The technique of hospital planning and construction tends constantly to grow more elaborate. An examination of the report of the committee on buildings—construction, equipment and main-

tenance, presented at the October meeting of the American Hospital Association, supports this statement, for in that report some eight hundred items, more or less, are enumerated, all of which demand consideration in the intelligent preparation of a plan for the construction of a single type of hospital building, the so-called private pavilion.

It would be ruinous to satisfy all of the current demands for technical elaboration. Choices are indispensable, and, unfortunately, the choices that are made are not always the wisest possible ones. The hospital planner must guard himself against the inclusion of costly novel and highly specialized features of construction that necessitate the elimination of standard service features of far greater value.

Impractical Features

By way of demonstrating the up-to-date character of their ideas (every new hospital delights in being "the last word") the planners of a hospital recently erected introduced such features as (a) pneumatic tube service; (b) metal shutters for darkening the operating room, operated by an electrical device under push-button control; (c) rubbish chute (in addition to a soiled-clothes chute); (d) a most elaborate quadruplicate system of artificial ventilation. It was evidently believed that these features conferred a certain distinction upon this notable hospital plant. Unfortunately, the hospital was not provided with porches suitable for use during the winter months; it has no running water in or near the wards; its single linen chute is located far from the sink rooms and wards; its utility sinks are too shallow to be serviceable; and its quiet rooms are lacking in general illumination.

In a statement on maternity hospital standards, an obstetrician who has made valuable contributions to obstetrical technique, protests against what he believes to be a disposition on the part of architects to assign the worst part of a hospital building to the maternity service. Such a protest does not really apply to current practice, but is based upon the sort of planning that was common ten or fifteen years ago. This distinguished critic stresses the need of separate buildings for maternity departments wherever possible, and, as an irreducible minimum, demands the assignment of separate and distinctive portions of general hospital buildings to the maternity service. He points out the danger of mixing maternity cases with medical and surgical cases and emphasizes the importance of separating septic from clean maternity cases.

All of these principles are not only theoretically accepted today, but they form the basis of much

actual practice. In Boston, Baltimore, Montreal, Chicago, Cleveland, Saint Louis, Philadelphia, New York, and elsewhere, distinctive maternity hospitals of the best character have been or are about to be built, and in many other places separate floors of general hospitals have been set aside for maternity work under the most favorable conditions. In three first-class multiple-story general hospitals now being planned, the maternity service will have the use of the upper stories, the delivery suite being placed on a floor by itself, above the level of the general roof. In a scheme of this sort, the maternity service is as distinctly and effectually separated from the general service of the hospital as it would be in a building of its own, for vertical separation is quite as effectual as horizontal, always provided that the section of the building allotted to the maternity department is a terminal section, not a thoroughfare.

Improved methods of clinical procedure in out-patient work have led to a demand for the more careful planning and more thorough equipment of out-patient buildings. In the old-fashioned dispensary the examining and treatment unit consisted of a wooden examining table and little besides. Several tables were usually assembled in a single room, and cubicle partitions or screens, to insure privacy for the individual patient, were conspicuous by their absence. If running water was available, it was in the proportion of one washbasin to half a dozen examining tables, and more often than not the basin was nowhere near the examining table. In the modern dispensary, individual examining rooms or cubicles predominate. If some larger rooms are retained, it is to facilitate the teaching of groups of students.

Dispensary Waiting Rooms

The organization of the dispensary record system imposes upon the architect a task which cannot be ignored. Waiting rooms, nowadays, whether departmental or interdepartmental, are of liberal dimensions, and are well lighted and ventilated. In the larger dispensaries one encounters laboratories equipped with steam, gas, and electricity, and occasionally with compressed air and vacuum. It is not an uncommon thing to find a lavatory, a small instrument sterilizer, and a writing desk in each small examining unit. And this equipment is not regarded as excessive. In general terms, an effort is made to equip the examining room of the dispensary in the same manner in which a physician would equip his private office.

In addition, it is desired to provide for a dispensary where the poor are treated, all of the diagnostic and therapeutic equipment of a per-

fectly appointed diagnostic clinic. The need is recognized of x-ray apparatus for both diagnosis and therapy, of a department of physiotherapy, of operating rooms, rest rooms, isolation rooms, and in the case of large children's clinics, of wash-rooms where children who are too dirty for examination can be cleaned up before they are presented to the clinician. In a busy dispensary the very best grade of interior finish, however costly its original installation, will eventually pay for itself by insuring continuity of service, by minimizing housekeeping labor, and by reducing the frequency of the employment of plumbers, plasterers, and painters.

Simplified Ventilating System

Ventilating engineers who, not so very long ago, strove for the introduction of elaborate ventilating systems, are now generally ready to cooperate with architects and consultants in simplifying the ventilating mechanism of hospital buildings. The plenum system has become a rarity. I can put my finger on only one or two hospital buildings of any consequence now in course of erection, that are being planned in such a manner as to be quite dependent upon a complete system of mechanical ventilation. In one of these the intention is permanently to seal the windows of a whole series of operating and auxiliary rooms, and justification for this procedure is found in the proximity of a noisy and dirty railroad yard which forbids the opening of operating room windows even during the summer. One suspects that in this hospital building air-conditioning will always be a serious problem, and that so far as the operating rooms are concerned, it will be necessary in summer not only to cleanse but to cool the admitted air.

A medical service building is a feature of a number of recent hospital plans. Liberally planned at the outset, and so placed as to permit of future expansion, this building represents an enormous improvement over the practice of former days, when x-ray departments, treatment rooms, and laboratories were obliged to share crowded basement quarters with kitchens, storerooms, workshops, autopsy rooms, and locker and toilet rooms for domestic servants.

The formulation of comprehensive standards of construction and administration for various types of convalescent homes is one of the events of the past year. This study was organized in New York, under the auspices of the public health committee of the Academy of Medicine, was participated in by institutional managers and clinicians especially interested in the care of convalescents, and deals separately with surgical,

medical, and neurological convalescents, and the needs of convalescent children. In general it recommends rural locations accessible by railway or motor bus, and favors fifty or sixty-bed units, divided preferably in homes for adults, into single or double rooms. Other features recommended are reading and recreation rooms, gymnasiums, an isolation unit, and occupational and physiotherapeutic equipment.

In the tuberculosis field, the plans of infirmaries for advanced cases tend to approximate the plans of general hospitals.

The interest of certain foundations in the provision of small hospitals for neglected communities has led to two separate studies of small hospitals of an inexpensive type, suitable for rural populations of limited resources. In these valuable studies, the planners have kept constantly in view the question of minimizing maintenance charges.

The so-called professional building, combining all the features of a doctors' office building with those of a private hospital, can no longer be disregarded in a summary of hospital practice in this country. A building of this character is described in the following terms: "The lower eight floors of the building are allotted to suites for physicians and dentists, each office having gas, electricity, and compressed air supply. There is a large separate x-ray and clinical pathological laboratory. The five upper floors comprise a hospital with private and semi-private rooms, its elevator service being apart from that of the office part of the building. Three operating rooms are located on the roof." This type of medical unit, it is claimed, comprising office building, private hospital and laboratories, "offers practitioners many advantages of practice, without loss of individuality and of a desire for and a sense of independence which draws so many into the profession of medicine."

Interior Finish and Decoration

Some of the more important hospital architects are calling skilled decorators to their aid to assist in the interior finish and decoration of hospital buildings. The participation of professional decorators in the selection of furniture and hangings for hospitals and nurses' homes has been more or less widely practiced for a number of years. In at least one instance a department of interior decoration has been set up as a permanent branch of hospital administration; and it is generally agreed that the concentrated attention of experts upon this phase of hospital planning and equipment will add to the attractiveness of hospitals.

An interesting situation has been created in one state, where the department of education, charged with the responsibility for the registration of schools of nursing, has undertaken extra-legally to direct the manner in which hospitals shall be planned and equipped, in order that they may furnish a background acceptable to the educational authorities for the education of the nurse. While a department of education functioning in the manner described is in a position to stimulate interest in proper standards of planning and construction, and may thus do a great deal of good, it is obvious that if the officers and inspectors of the department lack specialized training and mature judgment, they may, through arbitrary and ill-considered decisions, do a great deal of harm. Three things are needed in this connection: First, a proper legal basis for the activities referred to; second, the adoption of standards that conform to the best current practice; and third, the employment of trained investigators for the purpose of applying the adopted and approved standards.

Thorough Community Survey

The advisability of preceding the formulation of a hospital building program by a thoroughgoing survey of community requirements has been frequently stressed. After a program has been thus established upon a firm foundation, the duty of estimating the cost of construction is often left to persons who are not qualified by experience to make a reasonably accurate forecast. Mistakes of this character have been quite common, and have produced some interesting reactions. Thus Congress was recently asked to appropriate for a hospital building nearly \$500,000, more than was actually needed. In one instance that was brought to the notice of the American Hospital Association at the Louisville convention, a hospital caused a complete set of plans and specifications to be prepared and estimates to be obtained for the proposed construction in advance of its appeal for a building fund. Such cautious and thoroughgoing preparations can only be commended, but the procedure described cannot be practiced by government bureaus and will probably not be adopted by many voluntary hospital boards.

Those who have been active in hospital planning for any number of years will recall the difficulties that used to be encountered in interesting hospital boards in the care of contagious cases, on however modest a scale. The feeling long prevailed that the care of such patients was exclusively a public responsibility, and this conviction was reinforced by dread of contact with patients

suffering from communicable diseases. The principles of medical asepsis are better understood today. The means by which most contagious diseases are carried from person to person being known, there is more confidence in the ability of physicians and nurses to control contagion, and the average lay board is prepared today at least to consider the inclusion of a contagious ward in the building scheme of the general hospital. In the order of their attractiveness as money-getters in a drive for building funds, the clinical departments of a hospital might be graded as follows: (1) Maternity, (2) pediatrics, (3) surgery, (4) medicine, (5) convalescents, (6) communicable and contagious diseases, (7) chronic diseases.

There has been no recent deviation from the trend noticeable for many years past, toward the splitting up of large wards into smaller wards and single rooms. This trend is favored by a number of factors, including (a) the desire to add to the attractiveness of hospital surroundings, (b) the need of clinical classification, (c) a demand on the part of prosperous working people for private or semi-private accommodations. On all sides one hears the demand for "cheap private rooms." Doctors and patients are satisfied when a low price is put upon a room, and do not, as a rule, concern themselves with the question of construction or maintenance cost; but the genius has not yet appeared among us who is able to show how an attractive private-room hospital can be built *and adequately staffed*, at the low figures that are so frequently quoted as representing all that the lower middle class can pay. There seems to be no escape from the conclusion that the cheap private room involves, in the final analysis, either reduced nursing service or a contribution by the public toward the support of the patient occupying it; the private room to which a complete individual utility room is attached is, of course, not a "cheap" private room.

Central Tray Service

Central tray service seems nowadays to represent the overwhelming preference of dietitians, superintendents of nursing, and hospital executives in charge of small hospitals or of private pavilions of moderate size; in the food service plans for large public hospitals, however, the method of bulk distribution for the wards holds its ascendancy.

The finish of exposed metal work has always been more or less unsatisfactory to those responsible for the care of hospital buildings. The nickel plate generally employed, however attrac-

tive at the time of its installation, soon yields to the chemical action of polishing materials and eventually presents a serious problem. Solid white metals are, of course, more costly to install, and these, too, require some measure of care. Hospital housekeepers hope, therefore, that the recent report of the creation of a new and practically indestructible plating material, described as an alloy composed chiefly of metallic chromium, will prove to be well founded and that its cost will not be found to be prohibitive. It is claimed that this finish will not tarnish or rust under the most severe conditions, that it is many times harder and will wear much longer than nickel plate, and that it is immune to the effect of most acids. In appearance it is described as "resembling the soft blue sheen of platinum, offering a bright, mirror-like surface which maintains its luster without polishing."

Two substitutes for the ordinary lead insulation of x-ray rooms have been proposed during the past year. One of these is a structural tile containing barium sulphate in the mix. These tiles can be made with overlapping joints, and there is available also an x-ray cement mortar to be used in the setting up of the tiles. Rubber x-ray-proof combination mixtures have also been proposed in the hope of simplifying the labor and reducing the cost of constructing x-ray-proof rooms.

A manufacturer has placed upon the market, as a specialized contribution to hospital equipment, an x-ray door which has the outward appearance of an ordinary flush wooden hospital door, but in the center of the door is placed a thick continuous sheet of lead which is bolted in place securely with lead-covered bolts. It is hoped in this way to do away with the unsightly lead door that has so frequently been seen in x-ray rooms.

Advantages of "Ventilating Brick"

A so-called "ventilating brick" has recently been placed on the market. The face of this article, which is of metal and is of standard brick size, is louvered with a water drip at the top. In its interior it is transformed to a pipe having a three-inch diameter. It is made of cast iron or bronze, with a heavy galvanized iron flue. It is built into the wall, takes up no extra space, and may be used to advantage to ventilate hung ceilings and dead air spaces, bath rooms, utility rooms, and especially specimen closets and sink rooms.

Ready-made, air-tight clothes' vaults, designed for the fumigation of patients' clothes, etc., are available. These are gas-tight chambers in which formaldehyde fumigation may be conveniently

carried on. When formaldehyde fumigation only, without thoroughgoing interior disinfection, is desired, these chambers may be of service. It is conceded by the scientific advisers of the manufacturers of these chambers, that formaldehyde cannot be depended upon to accomplish more than a surface disinfection, and that it requires a very large volume of gas and a long period of exposure to penetrate several layers of even the thinnest fabrics, hence it is recommended that when fumigation is used, the chamber should remain closed for not less than eight hours.

Renewed efforts are being made to produce a reliable portable electrocardiograph which will permit hospital designers to abandon special wiring from the wards and out-patient department to apparatus stationed in the cardiographic laboratory. The need is for an instrument that can stand carrying and knocking about perfectly well. The new instrument does away entirely with the fragile fiber of the ordinary cardiograph and uses the principle of amplifiers. It is claimed that an instrument of this sort withstood the shocks of railroad transportation over a distance of a thousand miles without requiring any adjustment on its arrival at the laboratory.

WHERE SHOULD PERIODIC HEALTH EXAMINATIONS BE CONDUCTED?

"It seems to me that the hospital is the best place to conduct periodic health examinations because of its laboratory and x-ray facilities," says Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., in discussing the hospital's place in the nation-wide program of health examinations of the apparently well.

"There would, perhaps, be little objection from private physicians if the hospital gave examinations but not treatment to patients able to pay, but sent them with recommendations to their family physician. I believe that there is something to be said, however, on behalf of the family doctor who is equipped to do proper examinations. He might justly criticize the hospital for depriving him of a fee for the examinations. Nevertheless, not one general practitioner in five has the time or equipment to give thorough examinations, and many of them would probably be grateful for assistance from the hospital.

"I see no reason why private hospitals with sufficient facilities should not establish pay clinics in which these examinations could be carried out.

"Where the hospital carries out these examinations I question the advisability of the work being done by interns or even residents unless they are experienced."

Dr. Munger reports that Grasslands Hospital has set aside a portion of the time of one experienced physician (not an intern) for the purpose of conducting periodic health examinations upon employees of Westchester County and upon other persons who care to apply. The plan works out well so far as the mother's allowance cases are concerned, because social workers check up on them to see that they are examined. As the service is optional to county employees, very few, excepting those in the hospital, have availed themselves of this opportunity.

THE ADMINISTRATOR'S FIELD BROADENS

By Frank E. Chapman, Director, Mount Sinai Hospital,
Cleveland

AN ANALYTICAL observer of the hospital field over the past decade has witnessed many revolutionary and many evolutionary changes of a basic nature.

It is becoming more and more apparent that successful combating of disease can be achieved only by coordinated effort and it is being recognized that a hospital is but the grouping together of various facilities of personnel and physical plant for the prevention, diagnosis and treatment of disease. More and more is there being accepted the fundamental principle that hospital administration is but a popular means of describing the coordinating power of these various groups.

The day is past when any one man in medicine is sufficient in the diagnosis and treatment of disease. The rapid growth of laboratory practice; the broader knowledge of clinical medicine; the necessity for a degree of consultation service never recognized before, all these tend to the necessity of grouping at certain points all the facilities that are needed, to the end that the patient may, with a minimum expenditure of energy, of time and of money secure those things necessary for proper care.

The most graphic illustration of the place that the hospital is assuming in community life is an analysis of the type of occupancy hospitals are enjoying today as compared with their occupancy of a few years ago. It is not many years since more than 75 or 80 per cent of our hospital beds were occupied by surgical patients. Today this ratio is as low as 35 or 40 in a great many institutions. The obstetrical occupancy is attaining proportions that is producing a very marked prob-

lem of operation, and there are those who predict that the day is not far distant when a much larger proportion of the beds of our existing general hospitals will be assigned to obstetrical service, and that special obstetrical hospitals will become the rule rather than the exception in communities. This obstetrical occupancy is in a large measure

the result of the changed method of living, and is logical from an economic point of view.

There is another trend of occupancy, however, that is entirely different—the increased reference of patients to hospitals by physicians for observation and diagnosis. This is the result of the need on the part of the medical profession for diagnostic service. It is the recognition on their part of the economic soundness of sending patients to hospitals for diagnosis rather than making this diagnosis in the home. Such an occupancy conserves energy, and produces an efficiency of medical practice not attainable in the home. It also permits conservation of the attendant's time.

This trend is producing the real problem of hospital operation and is bound to force a higher grade of hospital administration. It is forcing an acceptance on the part of hospitals of all-inclusive health service as an integral part of their facilities and it is emphasizing the necessity for a closer coordination of each of the units of medical practice.

It is submitted that the hospital is the logical place for this grouping. If this premise is sound then it seems equally true that to the administration of a hospital is delegated the responsibility, first of supplying the facilities that are necessary, and, second, of administering these facilities in

A Complex Problem

THE hospital today is accepting a role in the health scheme that it did not even approach ten years ago. The ramifications and complexities of medical practice have produced a problem of hospital operation more complex than any in the past history of medicine. As a result the problem of hospital administration has grown in scope and has assumed an importance in the scheme of combating disease that is not comparable with the same problem of a short ten years ago.

The hospital today is the health center, or should be the health center, of the community that it serves, and, in its development it must take cognizance of every problem of combating disease. It must by the breadth of its vision not only supply those facilities needed for the care of the acutely sick but must reach out into the community, offering a program of prevention, of diagnosis and of cure.

the most efficient manner for all those concerned.

In submitting to the readers of *THE MODERN HOSPITAL* a resumé of administrative tendencies of the past, and a recitation of objectives for the immediate future, one must of necessity consider general trends of administration rather than impressions of individual institutions.

A study of a number of administrative schemes of hospitals that have been conceived in years gone by impresses one forcefully with the lack of a fundamental administrative principle incorporated in the scheme of organization. There has been a recognition of the need for a certain type of organization in the medical staff, in the nursing staff, in the dietary and other departments, but there has apparently seldom been expressed in the composite organization scheme of the institution a realization that all of these component parts cannot function to a maximum degree unless at some point they are coordinated under one responsible head. This can best be illustrated by reference to several types of organization.

One type recognizes the superintendent of the hospital as responsible for the physical plant, the superintendent of nurses as responsible for nursing performance, and the chief of staff as responsible for medical performance, each of these heads reporting direct to committees of the board of trustees.

Another type of organization sets up a two-fold control, namely, the position of medical superintendent and the position of business manager, with no liaison officer other than the president of the board of trustees.

Another type of organization contemplates the exercise of administrative function by various committees of the board of trustees.

Three Schemes of Organization

One of these three schemes of organization has been almost universally prevalent in the hospitals of America. It is submitted that not one of these is fundamentally sound in principle, and that their **proper functioning** is predicated to too great a degree on the personal equation rather than on soundness of principle.

First of all, it is believed that the allocation of administrative function to other than full-time personnel trained to the work is unsound and bound to be productive of poor results. Therefore the allocation of administrative function to committees of the board of trustees is bound to create incorrect procedures, by reason of the fact that the primary obligation of the member of that committee is not one of hospital administration. Furthermore, dividing the responsibility for the operation of the institution is bound to

produce chaos unless one of the individuals to whom responsibility is delegated is of a personality that will dominate the other individuals, and by reason of that personality will assume the responsibilities of centralized administration without proper status having been established.

A review of questions that are submitted on administrative problems cannot but forcefully impress an analytical observer that the basis for most of these questions and the reason for most of the problems of administration today is incorrect administrative set-up.

Centralized Authority

This defect is being gradually corrected and there is being accepted to a greater and greater degree a principle that has been found successful in all other fields, namely, that any activity irrespective of its character or of its scope must rely upon a centralized authority for coordination of effort and for motivation. As an illustration of this change in trend, an inspection of the administrative schemes of several of our newer and larger health groups will bear out the statement that this principle of centralized administrative control is being accepted.

There are those who are laboring under the impression that centralized administrative control of hospitals presupposes control on the part of the administration of the clinical practice of the institution. Nothing is further from the fact. The application of clinical procedures always has been and always will be the prerogative of the practitioner of medicine, and any scheme of administration that removes one iota of authority from the medical practitioner in the care of his patient is bound to fail. There is, of course, organized medical practice in the hospitals as represented by staff organizations, but this is strictly a banding together of medical men for purposes of cooperative medical practice, and is a point quite beside the question at issue.

There is, however, a vast problem of administration that for purposes of discussion might be called a medico-administrative problem, and this is rightfully within the province of the administration to discuss with members of the medical staff. Here administrative decision is not only desirable but pertinent, and the administrative function should be exercised. It is reasonable to assume that no efficient administrator will presume to offer a decision without the counsel of individuals especially qualified to speak on the subject under discussion. This applies not only to the medical staff but to all other members of an organization.

It is submitted that the principles of adminis-

tration as represented by centralized administrative control are as applicable to the operation of a hospital as are those identical principles applied to the operation of any other activity. There is, of course, a difference in their application, but with an efficient administrator competent to evaluate the service needs of an institution, inclined to take counsel of his or her workers and ruling with a beneficence, the end results are bound to be productive of great good.

If the deductions that have been submitted in this article are sound as regards an analysis of many administrative schemes, it would seem that the trend of hospital administration is towards a greater centralization of authority. The corollary to this is a greater demand for trained hospital administrators. Those who are in a position to know conditions state that requests for recommendation of efficient hospital administrators are becoming more numerous all the time, an indication that boards of trustees are recognizing that the problem of hospital administration is becoming more complex and that the necessity for a trained administrator is daily becoming of greater importance.

The fact that the establishment of training schools for hospital administrators is being widely discussed is another indication of the tendency of the times.

It is believed that hospital administration will increasingly be accepted as a field of endeavor requiring specialized training, and of an importance in our economic scheme that is immeasurable in terms of standards of the past.

LINCOLN HOSPITAL TURNED OVER TO CITY OF NEW YORK

The Lincoln Hospital, the 350-bed colored hospital in the Bronx, New York, has been transferred to the city for operation upon the payment of \$750,000 by the city, the sum to be used for the building of a new training school for nurses. The site for the school, a portion of the hospital ground, was retained by the board of trustees. The property taken over extends an entire block and includes the main building and six auxiliary buildings.

The transfer was made upon the recommendation of the board of estimate last June, that the city operate the hospital and provide the department of public welfare with an annual appropriation of \$100,000 for operating expenses. The action was sought because of the mounting annual deficit of more than \$75,000 as the result of the hospital's caring for city patients and maintaining an ambulance service at less than cost. According to the report of the hospital, 50 per cent of the patients treated were city patients and, although the city paid \$2.50 a day per patient, it cost the hospital \$4.14 per day to care for each patient.

The Arabs had already established hospitals in Spain in the eighth century.

THE HEART OF THE HOSPITAL

While riding in a street car the other day, two ladies sitting behind me were discussing a relative whom they had been trying to get into a hospital, but who, owing to a previous experience in an institution, had flatly refused and stated that "she would die first." I know nothing of the circumstances of the case, but there is food for thought for hospital workers in a remark of this kind.

One thing that we should always keep in mind is, that the people with whom we deal from day to day are not in normal condition and that occasionally a patient who is ordinarily well disposed is a very disagreeable person when ill. The same is often true of relatives of patients.

I remember we once had a lady in one of our best private rooms, with two special nurses and under the care of one of our specialists, who was of this type and no one could please her. The medicine was all wrong, the food was abominable, the nurses were not trained properly. Finally she refused to allow the intern to come into the room. Complaints came to the superintendent who approved requisitions for various delicacies to tempt her appetite; the nurses were extremely kind and patient; the doctor did his full duty, and so also did the intern by remaining out of the room when she refused to see him. But she finally left the hospital in a fit of temper before the doctor gave permission for her to go. This, of course, is an extreme case, but the "heart of the hospital" finally showed itself in this patient, for less than a month after she left the hospital she wrote a very nice letter to the superintendent, apologizing for the way she acted, thanking the doctors, nurses and all for being so kind to her, and referring a friend to us for one of our rooms. This patient became one of our best friends after she returned home and was in normal condition.

Humanity in Every Department

The "heart of the hospital" should not be located in any one spot. It should be at the front door, where the first impression by the patient is usually gained. The girl at the information desk should greet him with a smile and an evident willingness to assist. Do not let the patient stand around waiting, but make him comfortable in an easy chair until the details of admission are completed. The nurse and doctor in the examining room should tenderly examine the patient. The clerk should carefully and patiently assist in selecting accommodations, and the same careful, painstaking service should be given throughout the illness of the patient.

One of the principal departments of the hospital and one where the "heart" almost centers, is in the telephone operator. This is one place where the superintendent needs to devote a great deal of attention. I called up five hospitals the other day, and in each case I waited from one-half to three minutes for an answer. Three minutes to an anxious relative or to a sick man may seem like an hour. A human life may be lost through the laxity of a telephone operator. She should be quick, accurate and on the alert at all times. Every hospital should be equipped with a switchboard and plenty of phones, for without them no hospital can give proper service. They are the "arteries" of the hospital.

The "heart" should be not only in the superintendent, but it must be in all his assistants: at the front door, the information desk, the office, the telephone, the wards, the operating rooms, and, in fact, in the very air the patient breathes.—Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago.

AIMS AND TENDENCIES OF OUT-PATIENT SERVICE

By E. M. Bluestone, M.D., Assistant Director, Mount Sinai Hospital,
New York

THIS is a significant period in the history of the hospital. We are witnessing the passing of the old "dispensary." The researches of the American Hospital Association, the Committee on Dispensary Development of the United Hospital Fund of New York, and the Associated Out-Patient Clinics of New York, to mention only the most important organizations in the field, have challenged the hospital world, and the educational process that has been going on during the last few years bids fair to revolutionize the older traditions of the dispensary. The philosophy of out-patient service is undergoing a far-reaching change.

It is a period of awakening of which the outstanding characteristic is a scientific interest in the out-patient clinic as a public health institution. The patient and his neighbors are becoming alive to their medical needs, as a result in great part of the efforts of public health workers. Medical men are demanding better facilities and better conditions of service, also in a large measure because of these efforts. The governing authorities of hospitals are realizing more and more that the out-patient department is the place where the patient is seen during the most hopeful stage of his condition and at a time when prompt treatment holds out the greatest hope for a cure. It is therefore deserving of as much attention as the wards for whose special benefit the hospital, until very recently, believed itself to exist.

The inconsistency of the "bread-line" in the clinic has now become apparent to the progressive administrator. There should be nothing to discourage the patient from attending the clinic. We are beginning to learn that it is to the interest of everyone to keep his neighbor well, and that a

healthy community is of untold economic value and therefore worth its price. The burden (1) of searching out the patient at the earliest possible moment (a matter of propaganda), (2) of giving him adequate care, and (3) of

following him up to determine the remote effects of treatment (a fundamental requirement of medical science) rests with the community, of which the hospital with its out-patient department is the medical representative (at least with the poorer classes) quite as much as with the patient himself. The first and third of these functions deserve special mention in any review of recent achievements in out-patient service. The service thus required is bringing about an increase in expenditure, part of which it may be possible to shift

Outstanding Achievements And Progress

IN GENERAL, it might be said that the outstanding achievements in recent out-patient progress are first, a marked increase of interest in the out-patient clinic as an institution; second, the introduction of scientific methods in studying out-patient problems; third, the emphasis that is being given to the cooperative spirit among clinical and social agencies; fourth, the realization that every dispensary problem is more or less a social problem; and fifth, a more ready response from the community to propaganda in behalf of out-patient service. The effect of all this should be decidedly in the interest of the patient.

to the patient—another matter that has been studied by at least one large out-patient organization during the past year.

The tendency in hospital planning now is to consider a flexible hospital unit of which an out-patient department is a vital part. In-patient and out-patient departments are converging toward a single organization, and their essential unity in matters of construction, organization and administration is now receiving wider recognition. This is manifested in many ways. The tendency to route all applicants for in-patient care by way of the out-patient department instead of the admitting office of the hospital proper, is bringing about the planning of a closer structural relationship to accomplish this purpose. In the matter of construction, also, more space is being provided for clinical record facilities. This will eventually enable both in and out-patient departments to employ for each patient a unit history

centrally filed. If a true scientific attitude is to be maintained toward the patient and his successor, the clinical biography of a patient can no longer be scattered through the file of the hospital, the out-patient department, the social service department, and the offices of the staff physicians.

There is encouraging evidence that the administrator is becoming more interested in protecting the privacy of the out-patient through multiple structural subdivisions of clinical units. In the matter of construction also, there is now a larger allowance of space for teaching purposes. The education of physicians, whether they are on the staff or independent of it, is a continuous process in the progressive hospital and clinic. We must now have, in addition, teaching facilities for patients. There are food clinics and therapeutic kindergartens where patients must be taught.

Another question that has recently come to the fore is whether or not the radiographic and other diagnostic laboratories should be decentralized and have representation in the out-patient department in the same manner as the clinical pathological laboratory. The surgical clinics that handle minor fractures, the clinics in internal medicine and pediatric clinics will probably not be content in the future without facilities for fluoroscopy.

Providing for Out-Patient Service

The hospital builder must now consider the necessity for new clinics. Out-patient dental service is coming into its own, and dentistry is rapidly being recognized as one of the medical specialties. There is now a revival of interest in the food problems of patients with gastro-intestinal and metabolic disorders, and food clinics are being organized to teach these patients the preparation, calculation and control of their diets. Health classes are increasing in popularity—a sign of the times. Occupational therapy for out-patients now has a literature of its own. Specialization in out-patient practice is progressing; witness the asthma clinic as a branch of internal medicine; mental hygiene and classes for conduct disorders as branches of neurology; the correctional class as a branch of orthopedic surgery; and the various other sub-clinics for the treatment of special disorders. These problems in construction are rapidly assuming a financial aspect that hospital authorities will hardly be able to disregard.

In organization, too, there seems to be a growth of interest. A serious attempt, not yet wholly successful however, is being made to unify the medical staff for the in and out-patient departments in order to give the patient continuity of service and prevent, as far as possible, the old-fashioned habit of swapping horses in mid-stream.

A stronger tie between the two departments and a realization of the importance of out-patient service are bound eventually to produce the desired result.

Will Gratis Service Continue?

Whether it will be possible to continue to command the services of clinical assistants for routine medical work in the out-patient department without financial remuneration remains to be seen. There are signs of unrest. The greatest single cause of unhappiness in the life of the young clinician is the economic cause. The feeling in progressive hospitals seems to be that upon the solution of this problem depends in a large measure the comfort of the patient. The various methods of rewarding the medical man for work in the out-patient department are being studied and greater encouragement to serve is now being offered. Medical men working in the pathological laboratories, radiological laboratories (diagnostic and therapeutic), refraction clinics, the various clinics for physical therapy and arsenotherapy, are mostly salaried workers. This group may eventually have to be expanded to embrace medical men who attend to the routine work of the other clinics. Out-patient "fellowships" are coming into vogue as a partial means of relief. But whichever method prevails the economic value of medical service must receive wider recognition. In some quarters there is a justifiable demand for the services of the hospital intern for out-patient duties. The principle of the limitation of the number of admissions to conform to available medical facilities is being observed more and more.

There is a growing realization that clinical time is more valuable than clerical time. The physician could be relieved to a large extent of (a) clerical duties, as, for example, in the matter of records, and (b) other non-medical (technical) duties, if it were possible to finance an adequate secretarial staff to assist him in his work. Some dispensaries are solving this problem by recruiting a volunteer staff. These are some of the things that have been made the subject of recent studies, and the out-patient department of the next few years should, as a result, be a better place for the treatment of the sick.

Hospital policy with regard to the out-patient department is undergoing a decided change for the better. The out-patient department is no longer treated as an isolated clinical unit either with respect to the hospital, the outside medical profession, or the community that it serves. The importance of inter-clinical cooperation, shown by an increasing number of consultations, and of co-

operation with outside clinical and social agencies, has received proper emphasis. The purpose of this is to prevent duplication of effort and to encourage the scientific gathering of all discoverable facts that can be of help in dealing with clinical problems. The diagnostic clinic is coming to the fore as an essential part of out-patient service.

Out-patient service is broadening its social as well as its clinical field. A better understanding of the social moulds in which the patient is cast, and the importance of safeguarding his health regardless of his economic status, have led to the development in recent years of the "pay clinic," which furnishes adequate medical service for the lowest possible cost to a class of people who are not rich enough to afford the large fees of specialists and who cannot be treated as objects of charity. A model clinic of this character has been established in New York and has now passed beyond the stage of experiment. Here is a service to society that is far-reaching in its effects. Hospitals will doubtless profit by its example and will adjust rates for medical service in accordance with the social status of the patient as is now done with bed cases. The dispensing of medical and social service can no longer be interpreted in terms of charity for which the patient must plead as a result of urgent symptoms.

SAFETY DEPOSIT BOX FOR PATIENTS

Most hospital patients wear their jewelry and carry some money with them when they come to the hospital. In some cases these personal effects are stored under the pillow, in the clothing hung in a closet, in an envelope in the office or in one of the dresser drawers. It is obvious that none of these methods are as practical and business-like as the plan used by a Wisconsin hospital that has a series of safety deposit boxes in its own vault. On giving up his valuables, which the patient places in the box and locks, he is given a receipt and a duplicate key. The key is fastened on a necklace which the patient may wear if he wishes. This feature, though inexpensive, has been instrumental in building much good will for the institution.

The collection of poems, entitled *Shah Namah*, dealing with the ancient history of Persia, it is stated that the fire-worshippers had hospitals from the earliest times—an evidence of humanity that is not strange to the followers of Zoroaster. In Turnour's translation of the books of the southern Buddhists there is a statement that Buddha appointed a physician for every ten villages on the high-road, and built asylums for the crippled, the deformed, and the destitute. His son Upatisso built hospitals for cripples, for women and for the blind and diseased, while Dhatu-send built hospitals for cripples and for the sick.

Pindarus speaks of houses in Athens, officially chosen, where the sick poor repaired at fixed times for relief from disease. Those houses were, perhaps, comparable to our present-day dispensaries.

RADIO IN THE TUBERCULOSIS SANATORIUM

By Chesley Bush, M.D., Arroyo Sanatorium,
Livermore, Calif.

The advent of radio has been a great boon to the tuberculous wherever located, as the necessary prolonged bed rest isolates these patients who have always had a struggle against psychic depression and monotony. Those with a taste for study and literature have been particularly blessed, but such patients are few and far between. Radio now links the patients to the outside world with music, sports, sermons and educational talks. Very often the patient is now in a position to entertain his physician with information and stories heard over the radio, instead of the physician racking his brain for something new to tell the patient.

It was with such an end in view that we at Arroyo Sanatorium experimented with radio in its early years. We were fortunate in having a patient who was a radio "fan." Through his technical knowledge we were able to have a homemade receiving set to which we attached a dozen headphones at neighboring beds. Gradually adding to this original equipment, phone by phone, we were pleased to learn that we could carry one entire building on this set, then two buildings and finally three buildings with one hundred and forty headsets.

The receiving apparatus was an ordinary five-tube set and the secret of installation apparently was the hooking of the headphones into the wiring in "parallel," rather than in "series." With the success of this installation we moved the central receiving set to our main telephone office where it is now operated by our regular telephone exchange workers as part of their daily task.

We discovered, in addition, that we could hook an ordinary telephone transmitter into our receiving set in such a manner that the spoken voice would be carried through the amplifying tubes. This enabled each one of the 140 patients to hear whatever was said at the central receiving station. Then at the suggestion of one of our staff members we began to use this telephone transmitter as a microphone in order to broadcast to the patients our ordinary educational talks on tuberculosis and kindred health subjects. Hitherto all educational talks to the patients in a sanatorium have been handicapped by the fact that only a small portion of the patients could attend in a central meeting hall and those patients who needed the most instruction and the most encouragement, the bed patients, were unable to attend.

With this new scheme we have been able to include all patients in our instruction on tuberculosis therapy, and if patients have questions to ask they are answered over the radio so that every patient may benefit by the information given in the answers. Moreover, distinguished visitors are asked to address the patients and our little receiving set has been dubbed in radio parlance by the patients "K T B."

From our experience we believe that radio is now as important a part of a tuberculosis sanatorium, as an efficient medical and nursing staff.

In India, in the fifth century before Christ, it was the Hindoo custom for physicians to have female attendants who were chosen from a religious body of women bound by vow never to marry, and who waited on the women patients who were in need of medical attention. These nurses, by baths and massage, prepared the patients for examination, and assisted the physician in his care of women, especially after childbirth.

HOW SHOULD COMMUNITY HOSPITAL SURVEYS BE CONDUCTED?

By Michael M. Davis, Ph.D., Executive Secretary, Committee on Dispensary Development, and Haven Emerson, M.D., Professor of Public Health Administration, Columbia University, New York

IT SEEMS reasonable that before an organization expends ten thousand or ten million dollars in establishing or extending hospital or outpatient service, it would ask the question whether the expenditure was required by the needs of the community, or was prompted merely by the ambitions of an institution.

Reasonable as such a question seems, nevertheless asking it has not yet become a habit. To consider such a question is a novel experience to most institutions. The contributing public, which through private gifts or tax appropriations, ultimately foots the bills for hospital and clinic service, does not yet usually demand that such questions shall be asked. Community hospital surveys are new things, but the custom of making them has been growing with sufficient rapidity of late years to make it wise to take stock and consider why, when, and how they are worth while in every case.

Surveys of public health work in communities—in cities, states and counties—have been made for a number of years, analyzing the vital statistics, the organization, expenditures and effectiveness of the public health departments, sometimes also of the voluntary health organizations. A series of surveys of this type by the United States Public Health Service have appeared during the last fifteen years or more, as well as studies by certain private organizations, notably the Russell Sage Foundation. The ratings or appraisals of municipal health departments which have developed under a committee of the American Public Health Association, and of smaller cities under the American Child Health Association, are an evolution from initial surveys

and represent a fairly standardized procedure.

Studies of the prevalence of sickness, made by private organizations, notably the Metropolitan Life Insurance Company, as well as the United States Public Health Service, have contributed essential facts to our knowledge of needs for hospital service and other forms of medical care, but have not dealt directly with the hospital problem.

Some of the studies of health needs of a community, since the time of the Russell Sage Foundation's survey of Springfield, Ill., 1912-15, have included attention to hospitals; and studies by bureaus of municipal research and occasionally by business bodies, such as chambers of commerce (Pawtucket, R. I., 1913; Charleston, W. Va., 1917), have likewise dealt with hospitals and clinics, but only in an incidental way.

Community hospital surveys, whether of hospitals alone or of all health and sickness

services, have been called for by religious organizations, by city governments, by citizen groups withstanding political raids upon municipal hospitals, by municipal departments seeking guidance or support for a hospital building program, as well as by hospital boards, hospital councils, or community chests.

All these studies, whether of public health departments, of sickness, or of general community needs and problems were, until very recent years, conducted by organizations rather than by individuals, and usually by organizations of national scope. They were as a rule paid for by the organizations conducting them, or in a few instances by business bodies in the communities concerned. Only in recent years, since the War, has it come about that hospitals themselves, or

Essential Principles

COMMUNITY hospital surveys ought to precede all hospital development.

The importance of community hospital surveys as an aid to intelligent decision upon the wisdom of spending money before actually spending it, should be widely advertised throughout the country, particularly in this present era of hospital expansion.

Community hospital surveys should be conducted as public services, not as commercial enterprises; they can be largely, though not wholly, self-supporting; and they should be conducted under the auspices of bodies that are broadly interested in public service.

organizations including hospitals, have demanded and financed community hospital surveys, and it is again only recently that the actual conduct of such surveys has been in the hands of individuals who have carried on or directed the local study as experts or consultants on a fee basis.

Community Chests—A New Element

A new element was introduced into the situation with the rise of community chests. Since the War, the raising of funds by joint appeal, rather than by appeals of individual institutions, has swept the country. In 1915 there were only ten communities in which unified appeals, or community chests, existed, whereas now community chests exist in over 225 cities, including all the large ones, except New York, Chicago, Boston, Pittsburgh and Washington, and many small communities, even down to those of 25,000 population.

The directing authorities of a community chest are obviously placed in the position where the demands of any hospital for funds (either for construction or for maintenance) must be viewed in relation to the demands of other hospitals or of other forms of philanthropic effort. The managers of a community chest are in a position which invites them to view the demands of any one institution in the light of community needs as a whole. The value of long-range planning also becomes apparent.

Hence an increasing number of community chests have seen that community hospital surveys are worth having and worth paying for. Various tentative yardsticks for evaluating community needs for hospital and clinic service, methods of inquiry and other expedients for gathering needed facts have been worked out during the course of various studies of this kind, particularly in the extensive Health and Hospital Survey of Cleveland (1919-1920). The technique of community hospital surveys, however, needs much further development and is not yet standardized.

It seems to us, however, that sufficient experience has now been accumulated to indicate certain conditions that are required in order to make community hospital surveys really worth while. The broad scope and the varied elements involved in the study of hospital and clinic needs of the community is not always appreciated. The number of population, its rate of growth, racial and industrial characteristics, climate, prevalence of various important diseases, water supply, seasonal movements of population, are merely a few of the factors involved, which lie entirely outside the field of hospital administration itself.

The engineer, the statistician, the social scien-

tist, the business man, and the public health worker are, indeed, more intimately concerned with the facts and forces through which present and future hospital needs are to be judged than is the hospital administrator. The local organization and tendencies of the medical profession and the business factors affecting the financial possibilities of the community, as respects either public or private funds, are considerations.

Municipal, state, and medical politics have often to be considered before it is possible to interpret the facts gathered in the community hospital survey in such a way as to draw conclusions that will be of practical use to the community studied. It is comparatively easy to assemble a body of facts and statistics, but the ultimate test of the value of the community hospital survey is that it yield conclusions and recommendations that prove to be workable in the hands of the community itself. Surveyors depart after they have done their temporary job; what happens afterward is in the hands of those who live in the community.

Surveys Involve Varied Factors

Community hospital surveys involve such varied factors that no individual working independently can possess sufficiently broad knowledge to deal adequately with the problems presented. This is almost as likely to be true in dealing with a small community or an individual hospital, as with a large community or a large group of hospitals, for the problems presented are about the same, varying only in scope and the amount of detailed analysis required. For an individual to set up as a consultant in community hospital surveys and to work as an individual in this field, is much the same as if a physician were to announce that he was ready to handle "any kind of a case" in a consultant capacity, whether it be medical, surgical, ophthalmological, orthopedic, or neurological. Such a "consultant" would get little recognition from the medical profession or the public.

In the foregoing respects the making of community hospital surveys differs widely from that of consultation on hospital construction, an important but more restricted and technical field.

Furthermore, surveys generally lead to recommendations that involve conflicting interests in the community surveyed. The ambitions of individual physicians, of certain medical groups, or of institutional trustees, for expansion or other developments, are often irreconcilable with community interests. For this reason it has almost always been found impracticable to have the community surveys conducted by local individuals. There is too much fear of an initial bias and too

much real danger that "pressure" can be effectively exercised.

For the same reasons, the management of surveys under the auspices of a membership organization in which hospitals themselves are the ultimately controlling group, is fraught with danger. Any committee or board in which hospital officials or representatives are the controlling group should not be in a position to pass upon the conclusions of the professional staff making the survey. The attempt some years ago on the part of the American Hospital Association to maintain a bureau for conducting community surveys faced this difficulty. A community chest avoids it, because, while hospitals may be represented in its governing body, they are only one factor. The local committees that have generally been appointed to take charge of hospital surveys have recognized the importance of this point by giving representation to the institutions affected, but have made the majority of the committee citizens likely to be disinterested so far as institutional interests are concerned.

A serious objection to community hospital surveys by individual consultants on a commercial basis lies in the fact that the idea of community hospital surveys is a new one and that it needs, so to speak, advertising. The future of hospital development in this country, in which hospitals have been built in larger numbers than anywhere else in the world, depends largely on planning with reference to the community, rather than with reference merely to institutions. Advertising this idea means saving millions of dollars, and, furthermore, making millions now expended much more worth while to the sick, to the medical profession, and to the tax-payers or contributors.

Needs Non-Commercial Advertising

But advertising the idea cannot be done by individuals whose livelihood depends on it. At least, such advertising is subject to a large discount, and to grave dangers of commercialism by those who attempt to enter the field without proper qualifications. A non-commercial body such as a university, a national association, or a foundation, could advertise the idea extensively without advertising individuals.

It is appropriate and desirable that communities expecting to derive benefit from such surveys should pay their cost. The habit of securing a hospital consultant before the expenditure of thousands or millions of dollars for construction is fairly well established. The idea should be widely advertised that it is illogical and wasteful to call in expert advice to help to plan buildings, and not to seek similar advice in order to decide

whether or not the buildings are needed at all!

It is also true that there is and will be a call, at least for some years to come, for studies of hospital needs in small towns and in poor or sparsely settled areas that cannot themselves pay the cost of the work. Public or private organizations interested in public health and in better medical service must aid in such cases. Moreover, the newness and complexity of this kind of work makes it desirable that attention be given to its methods and to the improvement of its technique.

Should Be Developed as a Public Service

For the preceding reasons, community hospital surveys should be developed as a form of public service, rather than as a business undertaking, a branch one might say of public health work, using the term in a broad sense. This form of public service can be largely self-supporting, but should not be expected to be wholly so.

Among appropriate auspices for such service would be a national association concerned with some form of health work; or a foundation similarly interested, or a university. Probably there is room for several such undertakings in a country as large and as varied as the United States. A membership body directly concerned with hospitals might furnish auspices for a bureau or organization conducting community hospital surveys, provided that there were constituted a permanent technical board, representing the medical, public health, engineering, sociological, statistical, and business knowledge required. The full responsibility for reviewing the facts and conclusions reached by the staff of any survey should be in the hands of this technical board, which should also pass upon the professional qualifications of surveyors.

Only on such a basis could community hospital surveys under the auspices of a membership body of hospitals be sound and permanent. A health association, or a foundation, sponsoring community hospital surveys on any considerable scale, would undoubtedly constitute a similar board. A university would have upon the faculty all necessary advisory service to be organized and drawn upon as needed. The development of community hospital surveys under the auspices of foundations, universities, or other organizations not directly connected with the hospital field, would require that hospital administrators and others closely in touch with hospital problems be adequately represented on the sponsoring and advisory bodies. Academic aloofness from the practical problems of the hospital world is as real a danger as mere absorption in its details.

A COMMUNITY CATECHISM

By Haven Emerson, M.D., Professor of Public Health Administration, Columbia University and
Michael M. Davis, Ph.D., Executive Secretary, Committee on
Dispensary Development

New York

AN EXTRAORDINARY increase in the number of hospitals and clinics in the United States during the present generation, and the vast sums of money required for their construction and maintenance are beginning to cause us to think before we build.

About 150 hospitals in the whole country fifty years ago—about 7,000 today; some 200 out-patient clinics twenty-five years ago—over 4,000 today; sums approaching a billion dollars a year spent for construction and maintenance; hospitals in a community that are running with an average of 40 per cent of their beds occupied throughout the year—other hospitals in the same community that are soliciting the public for money to construct extensive additions; complaints that there is too little hospital service in many towns and rural areas; that charitable services are abused by those able to pay private physicians; that a few doctors have

many hospital connections and that many doctors have none; that the middle classes have too little access to benefits of hospital and clinic services that are available to the poor and to the rich; these are among the financial, social, and medical conditions that are throwing the problems of hospitals and clinics into the foreground of public discussion and have been responsible for causing many hospital connections and that many doctors selves and their needs before making up their minds as to what they ought to do.

The hospital is no longer a matter of faith or hope, its establishment should not depend on the mere belief of a need, yet it is an every day fact that we usually overlook the qualitative and quantitative analysis of its presence.

Putting down more or less chronologically the physical symbols of our social development in this

country, we find the church leading the list, with the courthouse and jail, the schoolhouse and library, the playground, the hospital and the health center, following about in that order. Churches are often superabundant, empty, competing institutions. Courthouses and jails rarely serve in harmony enough to credit them with more than a modest return on their cost and upkeep. For

schools we have a fairly close measure of need and usefulness and by degrees school boards and superintendents and janitors in a rising scale of relative importance are permitting school buildings to be used out of school hours and school terms so that the neglected adult may get a portion of the benefit of our so-called elementary educational system. Libraries, as commonly overcrowded and underserved as schools, come commonly nearer a full use than any other central social facility.

But what about the hospital? What questions shall we put be-

Brains Before Bricks!

IT IS not at all uncommon to discover that a modest expenditure for the care of chronic invalids and convalescent patients, and assistance to the visiting nurse service and an expansion of out-patient facilities will turn an apparent shortage of hospital beds in a community into an entirely satisfactory working margin of surplus beds. Hospitals should continue to be initiated, as in the past, through faith, hope and charity, but they should be intelligently planned and administered.

Their establishment should not depend on the mere belief of a need, but should be based on facts revealed by the answers to many searching questions. Comprehensive suggestions are here outlined for questions that should be satisfactorily answered.

fore and after building?

If the United States is spending \$300,000,000 annually for new hospital construction, how many dollars is it spending to find out how much of this new construction is needed?

We ought to ask two kinds of questions:

First, what do we want to know about hospital needs in a community, either as to new hospitals or as to needed lines of development in existing hospitals?

Second, what facts do we require in order to be able to answer these questions about hospital needs?

Of some hundreds of queries asked by community chests, boards of directors or superintendents, the most important are:

How many hospital beds are there per one thousand resident population for acute general

diseases? For surgical patients? For children and maternity patients? Are there as many as five beds per thousand?

Needs for beds vary. While Pittsburgh appears to need nine beds per 1,000 of the population, largely because of the high rate of physical injuries in the smelting, mining, and metal trades of that industrial center, many a southern city needs quite as many for its negro population as the northern white community does for the workers in especially hazardous trades.

Is there one hospital bed per two thousand of population for the acute communicable diseases?

How Much Out-Patient Service?

How much out-patient service is there for general medical and surgical patients? For children? For tuberculosis? For venereal disease? For heart disease?

Is there a convalescent hospital or home for children? For adults? For white and colored? For pay patients? For free patients? How many beds for each group?

Is there an institution or organization prepared to care for chronic patients? How many beds?

Is there provision for observation and diagnosis in the wards and in the out-patient clinic of a general hospital for persons with mental disease?

Is there provision in the hospital or hospitals for dental service, including oral surgery?

Does the personnel of the hospitals include a dietitian? Social service? Trained anesthetists?

May non-staff physicians care for their own pay patients in the hospital or hospitals for general cases? For contagious cases?

Are the professional services in the hospital maintained at the standards of the American College of Surgeons?

Are medical records made by physicians of private as well as of ward patients?

What proportion of the hospital service is paid for by fees from patients? What proportion of this income is from private cases? What proportion from paying ward cases? What proportion of the hospital work is for free patients?

What part of the expense of the out-patient service is met by fees from patients?

Do all hospitals make known periodically to the public the amount of work done, the receipts, expenditures, and costs?

Is there a community chest or other central organization raising and distributing funds to maintain the part of the work of the hospitals and clinics that is not self-supporting?

If not, how much money do the hospitals raise from the community through competing individ-

ual appeals for construction purposes? For maintenance purposes?

Some of the questions we have to ask in order to answer the preceding questions are:

What is the size of the population to be served? Resident and non-resident? Rural and urban? In the city or country or state where the hospital is located or from outside?

It is not uncommon to find 50 per cent of hospital patients non-residents, and often a high proportion of free patients are from other states or counties from which payment for care of indigents cannot be obtained.

What is the character of population, according to age groups, races, occupations, and per capita wealth?

At what rate is the community increasing?

In what direction is the population moving?

What is the status of zoning and town planning, especially in relation to transportation, and security of light and space about hospitals?

What has been the general death rate, the death rate from tuberculosis, and the infant mortality rate in the community for a five-year period?

What institutions or agencies, official and volunteer, are caring for the sick or dealing with prevention of disease?

Is there a visiting or public health nursing association? How many nurses on its staff? Does it do follow-up work for the hospitals and clinics?

How does the amount of sickness cared for at home by family physicians and visiting nurses compare with the hospital traffic of the community?

How Far Do Social Agencies Cooperate?

How far do the charitable agencies of the community cooperate with the hospitals by providing after-care for patients? How far do the hospitals and clinics cooperate with the charitable agencies by providing for their clients medical examination, report of condition, and needed treatment?

What per cent of all births in the year are cared for in hospitals and has this per cent been increasing in recent years? Are hospital maternity services operated in connection with prenatal, home delivery and postpartum service?

To what extent are hospital beds used as compared to beds available, according to type of patient—medical, surgical, obstetrical, children, communicable diseases, tuberculous?

What variations exist in the percentage of beds used from month to month or over a period of recent years?

At any one time, how many patients are in need of ambulatory or convalescent rather than

acute hospital care? What percentage of patients suffer from chronic or incurable conditions? How long are these kept in hospitals because of lack of convalescent or chronic institutions?

What is the proportion of patients who pay nothing, or pay part, or pay all the cost of their care?

What proportion of patients in the several hospitals are Protestant, Catholic or Jewish, as compared with the proportion of these groups in the population?

By what agencies are patients referred? By doctor, nurse, former patient, police, or charitable organization?

For what reasons—type of disease, economic condition, etc.—were patients refused admission?

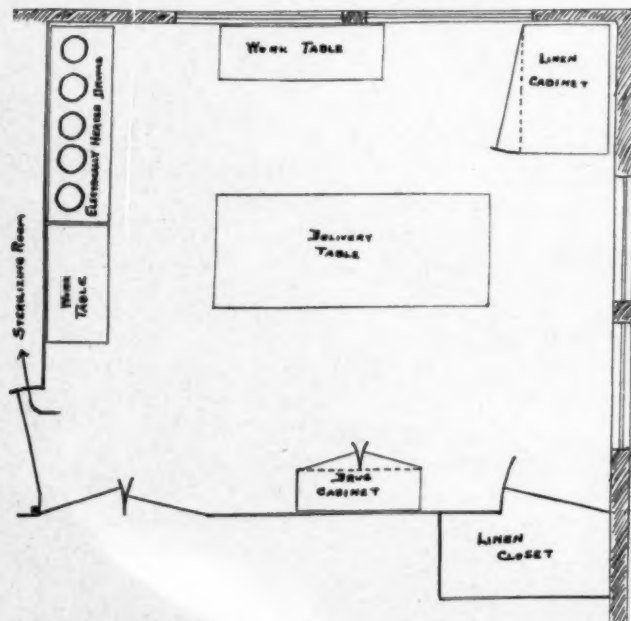
For what kinds of patients, according to sex, diagnosis, race, economic status, do physicians, nurses, social workers, or relief agencies find it difficult to get hospital or out-patient care?

One might greatly extend these questions. One might systematize and detail them. But until a community can answer satisfactorily most or all of the above questions no campaign for building funds for additional beds, private patient or ward, should be authorized.

UNUSUAL MATERNITY DEPARTMENT AT JOHN C. PROCTOR HOSPITAL

The John C. Proctor Hospital, Peoria, Ill., has an exceptionally well appointed delivery room in its maternity department, the layout of which is shown in the accompanying illustration.

It will be noted that directly adjacent to the main room is a linen closet of ample size. This in itself would be an appreciated feature in a great many hospitals, since there are many delivery rooms that have no linen storage near. In the Proctor Hospital, however, there has been



Layout of the maternity department at the John C. Proctor Hospital.

provided, in addition, a glass cabinet for extra linen and towels, while at the opposite side is a cabinet, smaller in size, that serves as a drug store.

Another piece of equipment that has proved of great value is the five-compartment, electric heater for the linen set-ups. Five set-ups are kept in readiness at all times so that obstetric service can be carried on with a minimum of delay. The drums for this electric heating apparatus are of the same size as the sterilizer drums. Because of this, steam sterilization may be had without changing receptacles.

Large windows and a battery of overhead lights provide unusual illumination.

GENERAL VERSUS SPECIAL HOSPITALS

By Thomas Howell, M.D., Superintendent, New York Hospital, New York

Apparently there is no reason to suppose that in the well managed general hospital the basic services are being slighted in the attempt to establish specialized services. As to the relative advantages of special hospitals and of highly specialized services in general institutions, most thoughtful men are of the opinion that the advantages are largely with the latter organization.

A specialist working in a general hospital is likely to have a broader perspective than one working in a special hospital. In the general hospital he has the advantage of association with men interested in other lines of work and he feels free to call upon them for consultation and advice.

When possible, general hospitals should have all the recognized specialties represented on their attending staffs. This is the most satisfactory arrangement for the physicians and the best for the patients. Special hospitals should have close affiliations with general hospitals.

ELECTRIC LIGHT SWITCH PLATES

One of the newer hospitals in Paris is completely equipped with plate glass for electric light switch plates, push plates on doors without knobs and also fastened over all names on doors. Eighteen-inch plate glass can be cleaned quickly, does not tarnish and is extremely durable when used in such places as the above. Its advantage as a covering for names and numbers, is that the numbers need not be repainted and frequent cleaning of the woodwork does not damage the lettering.

BOOKS FOR PATIENTS

The patients of an English hospital have an opportunity to loan books much as we do from the free public libraries. The books are listed in a catalogue made up in a loose-leaf book so that additions can be made quickly and with little expense. The books have been given to the hospital by interested citizens and those who have been patients. One of the many reasons for the growth of this idea is that each book has a printed notice asking patients to donate any books they no longer need, when they have recovered and returned home again.

King Ptolemy Seti of Egypt, thousands of years before Christ, was a patron of the "medical science" of his day, and was the author of an exhaustive treatise on anatomy. He even formulated a set of rules for the guidance of his inspectors who looked after the sanitary condition of his cities.

CONSIDERATIONS IN THE TRAINING OF HOSPITAL EXECUTIVES*

By Edward A. Fitzpatrick, Educational Director, College of Hospital Administration, Marquette University,
Milwaukee

IN THE old order the hospital superintendent was trained in the costly school of experience. "Trial and success," or "trial and error" as too often was the case, was the educational method. The superintendent either learned or just kept his job in innocuous desuetude. Nobody expected much. What could be expected? Was not the hospital conceived merely as a hotel or boarding house for the sick? Was not the superintendent an "exalted steward or clerk?" Who knew what was efficient hospital service? And when one reads that in one state last year the turnover in superintendents was 100 per cent in the smaller hospitals, one cannot but wonder that in such chaos so much good was done.

The "new order" is not achieved. It will require long, strenuous, intelligent and organized effort to approximate the new order. All that is unmistakable is that we are on the road, and apparently we know where we are going. Some evidences of this new order are (1) the attitude of present superintendents toward the superintendencies, (2) the increasing literature on hospital administration, (3) the appearance of books such as Davis', Chapman's, and Weber's, (4) the quality of some of the committee reports on special problems, (5) the announcement of definite courses in hospital administration by Marquette University, Milwaukee, (6) the progressive improvement of the hospitals in accordance with the intelligent and edu-

cationally effective plan of the American College of Surgeons, (7) the demonstration of effective organization and management of certain notable hospitals in the United States and Canada, such as Mount Sinai, New York; Massachusetts General, Boston; St. Mary's, Rochester, Minn.; Alameda County, San Leandro, Cal., and numerous others in the general and special fields.

These are merely harbingers of the new day. The hospital superintendent will in that day be a fully trained man, competent to deal intelligently with one of our greatest social institutions—the modern hospital. The present superintendent has been trained in the school of experience. In the evolution of professions there has usually been an intermediate stage of apprenticeship under a master before professional training developed, but in hospital administration this second stage is negligible. No effective, organized apprenticeship has ever developed. A superin-

tendent might take unto himself an assistant for apprenticeship but too often the training was not organized. It did not cover the area of hospital administration completely, it did not aim to give the student the intellectual coefficients of practical experience, nor did it initiate him in the history or literature of the subject.

A better method was the employment of assistant superintendents, who were paid a regular wage and charged with definite responsibilities. But this failed to provide the adequate opportunity for education. The assistant superintendent had much routine administration and little educa-

The Old Order Changeth

THERE is being born a new profession—the profession of hospital administration—and among the important influences in its creation are superintendents who are the product of the "old order" which changes and gives place to new.

The old order produced the present superintendents, and there are outstanding men among the leaders, who by sheer power of personality, mental ability and capacity to profit by experience have surmounted obstacles and have made their way in spite of handicaps and lack of appreciation. But in contemplating these successes one must not forget the failures or the fact that many who are incompetent have found havens in hospital superintendencies because no recognized standard of service had been set up, or was even regarded as possible. The hospital was still largely a charitable institution, where the fine spirit of holy charity did not find full expression.

*For a review of the Rockefeller report on the training of hospital executives and subsequent developments, including previous experiments in training centers, consult the report of the committee on training hospital executives of the American Hospital Association.

tional guidance in his own work. So, as an educational device it suggested no permanent method capable of adoption on such a scale as to provide an adequate supply of trained superintendents.

The Marquette University College of Hospital Administration is perhaps the most significant harbinger of the new day. It stands unequivocally for the professional training of hospital superintendents. That is its *raison d'être*. The establishment of a college of hospital administration was an act of faith in the new profession on the part of Marquette University. The granting of honorary degrees of doctor of science in hospital administration at the first commencement (1924) after the establishment of the college, to outstanding figures in the hospital field—Dr. S. S. Goldwater, Dr. Malcolm T. MacEachern, and Mother Mary Concordia of the Sisters of St. Mary, St. Louis—was designed to call attention in a dramatic way to the outstanding service of the individuals, to the high quality of scientific and administrative service they had achieved, and to their service to both the general public and to the field itself.

The evidences already cited—the developing literature, the standardization of hospitals, the achievements of exceptional superintendents—indicate clearly a professional attitude and the possibilities of a well developed profession. But there is need of a crystallizing agency to serve the hospital field by helping to organize the material available. One of the purposes of the Marquette school is to serve the field in this way. The studies in curriculum-making, and the problems of personnel, which make up the 1925 report of the American Hospital Association's committee on hospital executives are based on Marquette University's experience and were made available to the committee by the educational director of the college of hospital administration.

Organization of Materials

The next task that the committee is undertaking is the organization of the materials in various fields in cooperation with the members of the advisory technical board of the college which includes such men as Dr. S. S. Goldwater, Dr. C. E. McCorrbs, Frank E. Chapman, Dr. R. G. Brodbeck and E. S. Gilmore. Thanks to the splendid bibliographical work and package libraries of the Hospital Library and Service Bureau and the reference department of the American College of Surgeons, and the reports of the American Hospital Association, the Catholic Hospital Association, the American College of Surgeons and the American Medical Association, this service to the field can be expeditiously performed. The organ-

ized knowledge of the hospital field will then satisfy one of the requirements of a profession—a body of organized special knowledge. The university training will develop the special skill. It will be necessary to develop a genuine code of ethics for the profession, to serve as a third factor in promoting professional solidarity for a constructive public service.

Is University Training Needed?

Perhaps the need for a university training may be questioned. One answer might be that all the great professions are based on university training—law, theology, medicine, engineering, and even the new professions of dentistry, commerce, agriculture and education.

Marquette University has decided to undertake the training of hospital executives because it was felt that hospital administration was an occupation calling for the knowledge, skill and appreciation that is characteristic of genuine professional training, and that the cooperation of the various schools of the university would make possible the organization and presentation of the necessary knowledge and the development of the necessary skill. Hospital administration was to be put on the same educational and professional basis as medicine, law, the superintendency of schools and other professions.

A university training may be on several levels. It may be, at least, on an undergraduate or on a graduate basis. The university has provided for other professions short courses, summer courses, courses leading to certificate and to degrees. Two vital factors must be considered in connection with the courses offered by the universities (1) the nature of the demand for hospital service, and (2) the previous education and training of those seeking the courses.

The first demand would be satisfied by a thoroughgoing study of hospital service and particularly by a careful job analysis of the superintendency. The tentative studies made are represented in the curriculum presented in the Rockefeller and American Hospital Association reports and by the actual curriculum of the Marquette University College of Hospital Administration. This aspect of our problem need not concern us further at this time.

The second factor—the training and experience of persons seeking training—is a larger factor, but the question has been raised as to whether there is a demand for trained administrators. There is universal recognition of the need for a trained hospital personnel, but the demand is not active. Last year we received over a hundred inquiries but only approximately twenty students

took the course in hospital administration at the university. But this indicates interest on the part of present personnel from whom all the inquiries came. This interest is quite general as is evidenced by the correspondence of leading hospital superintendents and the editors of hospital journals. But, it may be repeated, this interest is not yet demand. Granted; but what of it?

It may be pointed out, then, that to provide training facilities before there is demand is to put the "cart before the horse." But the figure of speech only covers up the situation, it does not reveal it. Demand does not grow spontaneously, it is a matter of education. The need for training is admitted. The supply of trained executives will create the demand for their services.

The need for training of three types of persons for hospital administration is shown clearly in table No. 7 of the third presentation of hospital statistics by the Council on Medical Education and Hospitals of the American Medical Association. Fortunately, these statistics are given for various types of hospitals and can be interpreted accordingly. It should also be noticed that certain forms of almshouses are included, which would have to be taken into account if the total figures are quoted. Perhaps the most striking fact of the table is that in general hospitals the number of physicians, registered nurses, and lay people are approximately equally distributed, the percentages being physicians 32.5, registered nurses 28.1, and lay persons 38.6. The statistics are given in detail in the accompanying table.

The limits of this paper will not permit detailed consideration of the problems involved with each type of these persons. The matter may be presented in summary form. The nurse will ordinarily have a high school education and three years of training as a nurse. Two procedures are possible in dealing with her: one is to build up her academic training by having her proceed to a regular undergraduate degree, or to begin immediately further training for hospital administration on her present base. The nurse with experience in hospital work desires to secure her hospital administration training as rapidly as possible, and so the problem will be largely one of combining two years of administrative work with such general academic work as is possible in her nurse's training.

For the doctor who has had at least a year of internship, the hospital administration training may definitely be given on a graduate basis, followed, after at least one year's experience as intern, by a year of administrative internship.

The laymen who desire to specialize in hospital administration are of many types. Here are some actual cases:

1. College graduate without experience who desires to begin a career in hospital administration.
2. College graduate who has a limited experience in some department of hospital, but not executive.
3. Hospital superintendent of smaller hospital, without even a formal record of education equivalent to high school graduation, who merely desires to improve himself.
4. Laboratory technician (man) with high school

Table Showing Number of Physicians, Nurses and Others Serving as Hospital Administrators

Kind of Hospital	No. of Hospitals	Physicians	%	Registered Nurses	%	Lay Persons in Charge	%	Unknown
General hospitals.....	3793	1233	32.5	1066	28.1	1462	38.6	32
Nervous and mental...	593	449	75.7	9	1.5	134	22.6	1
Tuberculosis	476	283	59.5	57	11.9	128	26.9	8
Children's homes*	275	19	6.9	13	4.7	241	87.6	2
Maternity	262	55	20.9	37	14.1	168	64.1	2
Homes for aged and incurables*	195	19	9.7	3	1.5	171	87.7	2
Army, navy, marine and veterans ¹	172	162	94.2	....	....	10	5.8	..
Industrial	162	119	73.5	16	9.9	27	16.7	..
Convalescent and rest..	137	49	35.8	16	11.7	69	50.4	3
Isolation	111	54	48.6	17	15.3	40	36.0	..
Reformatory*	102	24	23.5	....	....	76	74.5	2
Children's hospitals ...	81	23	28.4	23	28.4	35	43.2	..
Indian	70	20	28.6	....	....	50	71.7	..
Prisons*	64	54	84.4	....	....	10	15.6	..
County almshouses* ...	58	9	15.5	....	....	49	84.5	..
Eye, ear, nose & throat	58	37	63.8	4	6.9	16	27.6	1
Schools and homes for deaf*	47	4	8.5	....	....	39	82.9	4
School infirmaries	41	15	36.6	6	14.6	20	48.8	..
Orthopedic	37	4	10.9	11	29.8	19	51.3	3
Skin and cancer	32	18	56.2	3	9.4	9	28.1	2
Schools and homes for blind*	26	1	3.8	....	....	24	92.3	1
Venereal	7	4	57.1	....	....	3	42.9	..
Miscellaneous	31	13	41.9	2	6.5	10	32.3	6
Total	6830	2668	39.1	1283	18.8	2810	41.1	69

*Refers only to the hospital department of such institutions.

¹Including all ex-soldiers' hospitals and hospital department of soldiers' homes.

education who desires to take a four-year course leading to a degree.

Depending on their previous training these persons may take either the undergraduate or graduate courses indicated for nurses or for physicians. But there are many in this group who have little academic training, but who have had considerable practical success in hospital administration and would like to have further training in their field. Because of their maturity and experience, the university ought to make definite provision for them. This may be done as in other professional schools by offering certificates, as distinct from degrees, for organized training extending over two years. This would cover substantially the same field as that for other persons. The nature of the demand for training in hospital administration by these definite groups indicates the desirability of organizing three different types of courses, such as are outlined in the report of the American Hospital Association's committee.

Three Types of Courses

These three types of courses indicate the demand for organized curricula. There is, as already intimated, demand for short courses of a month or even three months for hospital superintendents who desire help on special problems, such as records or accounting, or school of nursing or other aspects of hospital administration.

Another problem that cannot be discussed fully in this place is the academic requirements of the student in the university before he definitely enters on his professional training in the third and fourth year of his course. It would seem helpful if all the personnel of the hospital had a similar fundamental training. The Council on Medical Education and Hospitals of the American Medical Association has prescribed the pre-medical academic training of the physician. This furnishes a sound academic training and would be helpful to the nurse or layman who intends to enter the profession of hospital administration. It would therefore seem wise that as new members are recruited for the profession and enter the universities with the definite purpose of going into hospital administration, the fundamental academic training should be similar to the requirements of the Council on Medical Education and Hospitals of the American Medical Association.

It is a part of the best current educational theory that even for intellectual comprehension, conception should run along with experience, and theory should be supplemented by practice. If this is advisable for intellectual apprehension, it is indispensable in vocational preparation.

How to secure this supplementing of theory is a problem of all professional training. The pragmatic point of view in education has emphasized more and more the fact that in incidental (to living) learning, experience is the initial starting point. It presents the problem or raises the issue, and then all the relevant past experience has new meanings, and the wealth of experience of others, and of the world as represented in the library, are brought to bear on the situation to raise the level of experience, that is, to give it wider meaning, or deeper insight, or more effective power to direct new experience.

The best subject for professional training is, therefore the person of experience. Obviously here, too, there is a difference in person from the standpoint of (1) the nature and extent of the experience (2) the background of reading and training of the individual, and (3) his personality. Other things being equal, the longer or more varied the experience the better. Other things being equal, too, the richer the reading and the source of potential material in a process of constructive thought, the better. But both elements are vitally affected by the personality or nature of the person himself. Walter Bagehot, in a fine study of Shakespeare, uses a formula for the explanation of Shakespeare that may be helpful in this connection. Mr. Bagehot says that the greatness of Shakespeare is the result of a first-rate imagination working on a first-rate experience. Experience is necessary, but it must be utilized as the raw material of intelligence for the better guidance of life.

Balance Between Theory and Practice

Theory without practice, said Kant in substance, is empty, practice without theory is blind. And this expresses the idea of Bagehot if we interpret it properly, but too often it seems merely to mean that people should have theory and practice together, or a period of practice after the theoretical work.

Routine administration is not educative. Unless theory and practice are definitely coordinated, they are, from an educational standpoint, of little significance.

This point of view necessarily requires a careful study of hospitals and hospital experience in order that students may be assigned for practical work under proper conditions to secure the necessary educational coefficients of the experience.

It may be necessary to use as the field of training for hospital administration the solution of this problem worked out at Cincinnati. The cooperative plan of engineering training was on the verge of breaking down because of this lack of

coordination of theory and practice, when the device was "hit upon" of appointing a man acquainted with the university classroom and the university curriculum, who also knew the shops, whose sole duty it was to acquaint himself thoroughly with what was happening in both places and see that the work was coordinated. This is the "coordinator" who saved the cooperative method.

Universities are generally adopting as an integral part of medical training a clinical year. This is essential in any plan of professional training where practical training or laboratory work, or other forms of experience are a part of the training, but where such experience is designed primarily to develop in the student understanding rather than professional skill. The test of the entire training will come when the student enters upon professional practice upon his own responsibility. It is felt that this entrance into practice under actual conditions should be a guided and directed experience under competent medical educational supervision, where the young intern maintains the attitude of a learner (which he should keep throughout his career) and a competent supervisor sees that he gets the educational coefficients of his practice.

There exists the same need in the new profession of hospital administration.

Upon graduation from a university course such as is outlined, there will still be need for further training. The assignment to a hospital and the performance of routine tasks would not meet the requirements of this additional year of experience which a sound educational policy requires.

Educational Requirements

To satisfy the educational requirement, it will be necessary:

1. That the environment (the hospital) shall have in it potentially educational factors.
2. That the student shall be assigned a well rounded series of tasks or duties, increasingly difficult, testing out the intramural teaching and covering a wide range of the duties of the hospital superintendent.
3. That the work of the student shall be under the immediate supervision of competent hospital personnel, interested in education, and under the general supervision of university authorities who are informed on the best current practice in hospital administration.

Many technical problems are involved in the working of the curriculum, arrangement of topics and sequence of subjects, but these are subordinate to the main considerations that have been presented in this paper. The whole question

must be recognized as fluid at this time, experimentation should be heartily encouraged and educational supervision must be given a prominent part in the development of the educational program. With the cooperation of the hospital associations, the present executives of hospitals and training centers, the American hospital will be able to maintain its supremacy among nations in the hospital field and, what is more important, better serve the American public.

"PHYSICIANS' GALLERY" INTERESTING FEATURE

The De Kalb Public Hospital, De Kalb, Ill., has brightened up its first floor corridor by a large, well-lighted board on which has been hung the photographs of all the doctors and surgeons who have practiced in that institution. This board is shown in the accompanying photographic reproduction.

The board, in addition to being a collection of photo-



graphs of the various practitioners, has been given historical interest by the inclusion of a photograph of the first drugstore in De Kalb, the first patient in the present institution, and other pictures of general interest. In the upper end panel, for instance, is an ancient photograph of an old Indian chief, the first "medicine man" in De Kalb County.

A midwest hospital has created a great deal of comment by its unique slogan—"A Hotel for Sick Folks." The idea is to get away from the old suggestion that people must suffer in a hospital.

WHAT IS BEING ACCOMPLISHED BY THE GOVERNMENT HOSPITAL GROUPS

U. S. ARMY HOSPITALS

By Lieut.-Col. James M. Phalen, M.C.,

U. S. Army, Washington, D. C.

SEVEN years from the armistice that put an end to the World War finds the hospitals of the Army only partially recovered from the disruption into which they were thrown by the sudden expansion incident to that war.

The main difficulty is that nearly all of the larger hospitals are compelled to keep in service temporary buildings that were built for emergency and are now in poor repair and in need of replacement by permanent construction.

This is especially true of Walter Reed General Hospital, Washington, D. C., and the Station Hospital, Fort Sam Houston, Texas. Appropriations are already in sight for the construction at the Walter Reed Hospital of ward buildings, kitchen and dining hall to provide for the care, in permanent buildings, of 850 patients. At Fort Sam Houston the greater number of the patients are in temporary buildings for which there is no prospect of early replacement. While designated as a Station Hospital this institution is in effect a general hospital and the plans for its permanent buildings contemplate accommodation for about 500 patients.

Wooden Structures Being Replaced

Letterman General Hospital, San Francisco, is relatively better housed. While it is using some temporary buildings, no patients are being cared for in them. It has, however, some old wooden wards that are being replaced from time to time by concrete construction. It is not contemplated to exceed the pre-war capacity of about 500 beds.

Fitzsimons General Hospital, the great tuberculosis hospital at Denver, was a product of war time. It was hastily built of semi-permanent construction, and while its bed capacity as originally planned was later increased, its utilities were not increased accordingly. The problem of bringing these utilities up to the needs of the hospital population is the one that faces this institution. The bed capacity is approximately 1,200, and the idea is to provide efficient care for that number.

William Beaumont General Hospital at El Paso, Texas, was also a war-time conception but its actual construction was carried out largely after the armistice and was, therefore, unhurried. Its buildings are of hollow tile and concrete, only the

connecting corridors being of wood. The latter are in poor repair, but with their replacement, the Army will have here its most complete large hospital. It has a capacity of about 300 beds.

The grounds of the Army and Navy Hospital at Hot Springs, Ark., did not permit of any war-time expansion. Its bed capacity has, however, been gradually increased without corresponding increase in the utilities. At the present time, its kitchen and dining hall facilities are being increased by an addition. There is urgent need here of a new heating and power plant.

The above-named hospitals are caring for about 2,000 patients for the Veterans' Bureau.

Recently there has developed a movement, encouraged by the surgeon general, to build up in certain corps areas that are not near any general hospital, a special hospital to be manned and equipped for the care of the more seriously ill patients of the corps area. Hospitals that have been so designated are those at Fort Strong, Mass., Fort Totten, N. Y., Fort McPherson, Ga., and Fort Sheridan, Ill. Such establishments are caring for many patients who would otherwise have to be transferred long distances to general hospitals.

The repair of the station hospitals, like that of those mentioned above must wait on increased appropriations from Congress. While funds for construction and repair are thus inadequate, it should be kept in mind that there never has been any lack of money for supplies and equipment for these hospitals and that the military patient has always been well taken care of if not always well housed.

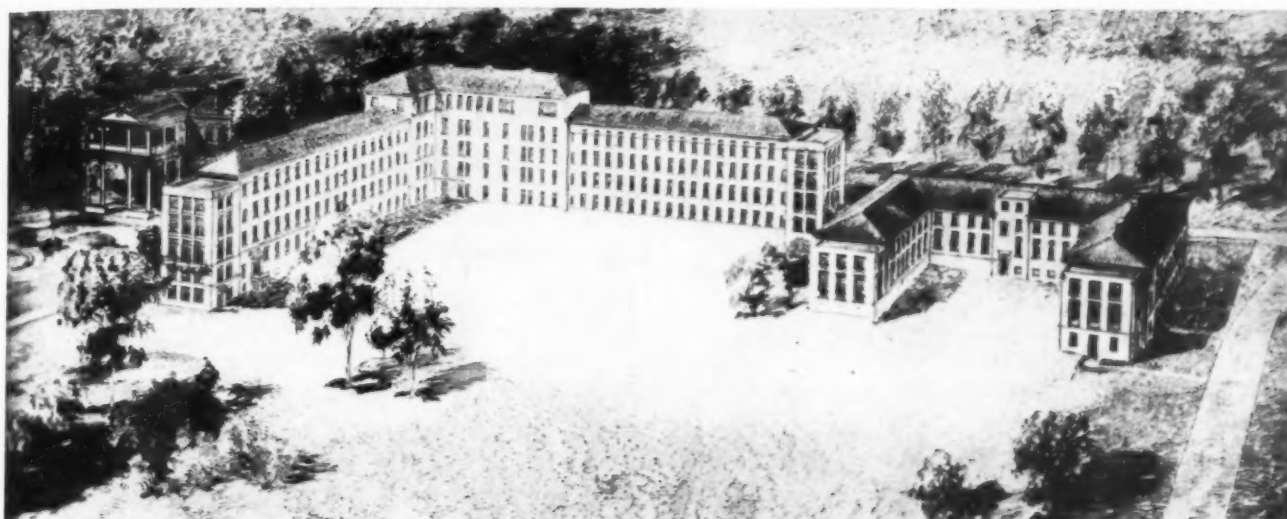
U. S. NAVY HOSPITALS

By Captain A. W. Dunbar, M.C.,

U. S. Navy, Washington, D. C.

OUTSIDE of the hospital service of the medical department of the U. S. Navy, which is primarily of more interest to those especially concerned with civil hospital work, the medical corps is engaged in the physical selection of the naval personnel, the maintenance of physical fitness, and the elimination from the service by medical survey of those permanently disabled.

Incident to the interests of the United States in Guam, Samoa, the Virgin Islands, Haiti, and until recently in San Domingo, the medical department has undertaken large public health problems in these localities with gratifying success.



U. S. Naval Hospital, Mare Island, Calif.

From 1,200 to 1,600 beds in our naval hospitals are constantly occupied by beneficiaries of the Veterans' Bureau, and the indications are that there will be an increasing demand for beds from this source.

Since the reviews on the above subject that appeared in *THE MODERN HOSPITAL*, January, 1923 and 1924, no new projects have been undertaken. There is a continuance of the San Diego Hospital program, which contemplates an ultimate 1,000-bed capacity. During the past year the north ward, the nurses' home and a building combining a physiotherapy department, psychopathic ward and out-patient service, have been completed. Proposals are about to be issued for three sets of quarters for the medical staff, a dormitory building for the hospital corpsmen and a contagious unit. The hospitals corps building, aside from dormitories for about 100 personnel, will contain lecture rooms and laboratories for use in the instruction of hospital corpsmen. The contagious disease unit will be constructed of reinforced concrete and designed in harmony with the other buildings at this hospital. It will contain twelve quiet rooms, four eight-bed and four twelve-bed wards, with a solarium in connection with each ward. The building is designed to give a separate entrance for each unit, enabling an occupant of any one unit to leave the hospital without coming in contact with other cases. Provision is made for shower baths and a change to sterilized raiment as he leaves the building.

The organization of the out-patient service at the San Diego Hospital is in line with the recent policy of the Bureau of Medicine and Surgery, having the advantage of bringing this work where the various laboratories and also the services of the specialists of the hospital can be utilized in the treatment of the out-patients. It also has the

advantage of giving a more varied service to the hospital staff. At the present time the admission of women and children to naval hospitals is not authorized by law, hence they cannot be accepted as hospital patients.

At the Naval Hospital, Mare Island, Calif., a reinforced concrete unit, consisting of seven wards having a capacity of about 250 beds on eight-foot centers, is about to be commenced, the plans and specifications having now been completed. This unit will consist of two wings each having four full floors, with a partial fifth floor containing the operating suite and x-ray department.

Building Well Planned

One ward on the ground floor will be fitted for venereal disease cases. The corresponding floor in the other wing will contain a complete physiotherapy department, including hydrotherapy, thermo- and electrotherapy, actino- and mechanotherapy apparatus, with the necessary waiting and dressing rooms. Near the junction of these wings on this floor will be the bag room, for the safekeeping of patients' baggage.

The location of the operating suite on the top, or fifth floor, gives advantageous lighting. This suite will consist of two main operating rooms, provided with an observation stand, with the usual scrub-up, anesthetizing, recovery, preparation, and sterilizing rooms.

The location of the roentgenological department, adjacent to the operating suite, is of obvious advantage.

Should further construction be required at this hospital, a similar unit can be erected at the other end of the present wooden hospital building, which in turn may eventually be replaced by a reinforced concrete administration building.

Adjoining the new unit, an officers' ward, containing fifty rooms, each with its own bath and toilet, will be erected. This building will have independent culinary arrangements and a dressing and minor operating room.

There has recently been completed at this hospital a psychopathic ward, containing space for thirty cases in small wards and rooms.

Proposals are to be issued for a contagious ward building for this hospital similar to the one to be built at the San Diego Hospital.

Third Ward Wing at Puget Sound

At the Naval Hospital, Puget Sound, Wash., a third ward wing of two stories, containing sixty-eight beds, has been completed. It is probable that at some future date a fourth wing will be required for this hospital.

The new construction at the Naval Hospital, Canacao, P. I., briefly described in previous issues, is now under way.

The above brief summary comprises practically all of the present building program of this bureau. The hospitals still have in use many temporary buildings, the life of which is, of course, limited and their continuous maintenance is quite expensive.

The system of accounting introduced about three years ago, with the publication of a quarterly and a yearly comparative statement of the various hospitals, has proved eminently successful in producing a reduction of cost of maintenance of the hospitals. It is believed that this has been accomplished without any reduction in the character of services rendered and it is reported to have improved the service through stimulating closer attention on the part of the administrative officers.

Professional Function Given Greater Attention

The professional function of the hospitals is receiving equal or greater attention, particular care being exercised in the assignment to the staff of medical officers trained in the various specialties. The larger hospitals have been surveyed by the committee on hospital standardization of the American College of Surgeons and have been approved.

The recent policy of training interns in the larger hospitals has necessitated the development of a teaching staff. The weekly conferences held by the various staffs tend to encourage the reporting of end-results, which are also a matter of interest to the Bureau of Medicine and Surgery, whose naval mission is not only the saving of life and suffering but also the return of the trained personnel to a duty status.

U. S. VETERANS' BUREAU HOSPITALS

E. O. Crossman, M.D., Medical Director,

U. S. Veterans' Bureau, Washington, D. C.

THE U. S. Veterans' Bureau has at present fifty-one hospitals in operation, with a total bed capacity of 20,867. Assigned to these institutions are 646 medical officers, 81 dentists, 200 attending specialists, 1,428 nurses and 915 technicians.

The hospitals are grouped for purposes of administration and special treatment into three types of which seventeen are devoted to general medicine and surgery, eighteen to tuberculosis, and sixteen to neuropsychiatry. The locations of these hospitals are as follows:

GENERAL MEDICAL AND SURGICAL.

Washington, D. C.	Ft. Thomas, Ky.
Atlanta, Ga.	Maywood, Ill.
Boise, Idaho.	Portland, Ore.
Dwight, Ill.	Algiers, La.
Tacoma, Wash.	Memphis, Tenn.
Lake City, Fla.	Muskogee, Okla.
St. Paul, Minn.	Tuskegee, Ala.
Kansas City, Mo.	Jefferson Barracks, Mo.
	Excelsior Springs, Mo.

TUBERCULOSIS.

Alexandria, La.	Ft. Harrison, Ky.
New Haven, Conn.	Outwood, Ky.
Whipple Barracks, Ariz.	Ft. Lyon, Colo.
Tucson, Ariz.	Walla Walla, Wash.
Ft. Bayard, N. M.	Rutland, Mass.
Oteen, N. C.	Legion, Tex.
Camp Kearny, Calif.	Tupper Lake, N. Y.
Minneapolis, Minn.	Castle Point, N. Y.
Aspinwall, Pa.	Livermore, Calif.

NEUROPSYCHIATRIC.

Palo Alto, Calif.	N. Little Rock, Ark.
Waukesha, Wis.	Bronx, N. Y.
Perry Point, Md.	Sheridan, Wyo.
West Roxbury, Mass.	American Lake, Wash.
Philadelphia, Pa.	Northampton, Mass.
Knoxville, Ia.	St. Cloud, Minn.
Augusta, Ga.	Camp Custer, Mich.
Gulfport, Miss.	Chillicothe, O.

Many of these institutions which when first acquired were of temporary construction or inadequate to the needs of the bureau, have been converted into modern hospitals with permanent buildings of the latest design, equipped with approved facilities and staffed with medical officers of experience, aided by consultants of recognized attainment. All of these hospitals, except the one most recently opened, have been surveyed by the American College of Surgeons and out of the fifty, forty-five were fully accepted and two conditionally accepted by that organization, as meeting with its requirements for standardization.

In each hospital clinical conferences of the medical staff are held upon all cases on admission and discharge and while under treatment,

and a special effort is made to obtain an autopsy in every case of death. Complete physical examinations are performed, including all specialistic and laboratory investigations, the reports of which are carefully assembled, indexed, and systematically filed. Treatment in all departments is supervised by the clinical director, who is responsible for every phase of the professional service of the institution.

Personnel Especially Qualified

The surgical department, special clinics, clinical laboratory, x-ray laboratory and physiotherapy department are conducted by especially qualified personnel, under the direction of medical specialists, and these departments are provided with all necessary modern equipment. The nursing service is rendered exclusively by graduate nurses of recognized schools. The ratio is one nurse to ten patients.

All food is selected, prepared and served under the direction of trained dietitians, including the mess for ambulant patients and hospital personnel as well as special tray service. There is but one grade of food for all groups to be served and the menu for the medical staff, nurses and other employees is the same as that for the patients.

Occupational therapy is an important activity of every hospital and is administered by a particularly high type of personnel, (aids trained in arts and crafts), upon prescription of the ward surgeon. Special provision is made for the diversion and entertainment of patients. Radio receiving apparatus is installed, in many instances with sufficient head-sets to supply each bed patient. Special auditoriums are accessible for motion pictures and vaudeville, religious, patriotic, social and other meetings. A well-stocked library for the patients is an important feature of each hospital, and is recognized as of therapeutic value. In addition to an abundance of well chosen fiction, there are books of travel, biography, science, philosophy, and other subjects, with a particularly large section devoted to vocational education.

With the exception of hospitals in cities, each institution is a self-contained community, with its own water supply, sewage disposal plant, light and power plant, police, fire department, farmers, carpenters, plumbers, electricians, mechanics, and laborers. In some instances the Government reservation consists of several square miles, and it has been found profitable to maintain herds of cattle as well as poultry plants. In practically every section in which a new hospital has been established by the bureau, it has been welcomed by the citizens and regarded as an asset. Cordial

relations have been established between the civic, fraternal, patriotic and religious organizations of the community and the hospital, with advantages to each.

Two hospitals of the bureau are rather unique. One at Tuskegee, Ala., is devoted to the treatment of negro beneficiaries exclusively, combining the departments of general medicine, tuberculosis and neuropsychiatry, and is staffed throughout by colored physicians, nurses, dietitians, and other employees. The other hospital of special interest is that at Washington, D. C. This has been made a diagnostic center for the thorough study by every means available in modern medicine of all cases that have been referred to the director of the bureau as subject to differences of opinion or difficulty in diagnosis in other hospitals or regional offices, or in institutions not under the bureau's immediate jurisdiction. This hospital is fully equipped for this purpose, and is staffed by medical officers of exceptional qualifications, with attending specialists from the faculty of Johns Hopkins University, Baltimore, Md., and the leading practitioners of Washington.

The peak of hospitalization was reached in March, 1922, when there was a total of 30,800 ex-service men hospitalized. (This included contract institutions, as well as government hospitals). A second peak of 30,750 patients was noted in February, 1925, as a result of the legislation of the previous year by which veterans of any war, expedition or occupation in which the United States has engaged since 1897, are hospitalized, as well as veterans of the World War. This may be exceeded during the ensuing winter.

Present Status of Veterans' Hospitals

Two or three years after the war it was felt that the greater part of the work in the hospitals devoted to general medicine and surgery had been completed, and that later the majority of them would be closed or converted into hospitals of another type. It is becoming apparent however, that cases of cardiac, renal, gastro-intestinal diseases and neoplasms are increasing, doubtless because of the inclusion of the older veterans. This condition will be augmented by the aging of veterans of the World War. On the other hand, there is a definite decline in the number of cases of tuberculosis. This may be because the decennium of greatest incidence of clinical tuberculosis coincides with that of the draft age, and that five years is the average expectancy of life for a consumptive, and that it is now seven years since the cessation of hostilities. A very different problem is presented by the progressive increase in the number of neuropsychiatric cases for which there

is at present an urgent demand for beds. This is particularly true of the psychotic type. No definite estimate can be made as to the time when the maximum load of such cases will be reached.

The problems which arise in connection with the administration of these hospitals have received the careful study of the medical council, in conference and as individuals. This organization is an advisory body which meets in the office of the medical director every three or four months, for the consideration of the medical work of the bureau and the maintenance of a high standard of professional service to its beneficiaries. In the intervals between conferences the counselors visit the hospitals in their vicinity making informal inspections and offering advice to those in charge.

U. S. MARINE HOSPITALS

By F. C. Smith, M.D., Chief, Hospital Division,
U. S. Public Health Service, Washington, D. C.

SEAMEN from American merchant ships are the principal beneficiaries for whom twenty-five marine hospitals and 128 other relief stations are operated. The medical care of these men has been, since 1798, a contribution by the Government for support of the merchant marine* and is the oldest function of the U. S. Public Health Service. Next in numerical importance of beneficiaries are patients of the Employees' Compensation Commission (injured Government employees), Coast Guard and Veterans' Bureau, respectively, lepers, and immigrants.

During the fiscal year ending June 30, 1925, 43,285 patients were treated in hospitals and 166,000 in out-patient offices; 1,342,000 hospital days' treatment, and 493,771 out-patient treatments were furnished, and 76,661 physical examinations made that required special reports to other Government agencies.

Among persons so examined are all pilots, masters, mates and ships' engineers applying for license whose vision, color vision, auditory sense and physical condition are carefully tested. They are also instructed and then examined by officers of the Public Health Service in the administration of first aid, in which proficiency is required by the Steamboat Inspection Service. Other persons examined included 18,700 Civil Service applicants, 13,000 Coast Guardsmen, 7,000 patients of the Employees' Compensation Commission, and 18,500 seamen seeking special ratings. An aggregate of 520 doctors and dentists (including 158 attending specialists), 391 nurses, aids, and dietitians, and 1,710 other employees are engaged in these

relief activities. During the past year 17,900 clinical laboratory examinations and 55,000 roentgenological examinations were made, and more than 100,000 surgical operations performed.

With the exception of the marine hospitals at Norfolk, Va., Savannah, Ga., Buffalo, N. Y., Pittsburgh, Pa., and Carville, La., respectively, the latter devoted to lepers, the hospital buildings are old, although the equipment and methods are modern. Eight of the present hospitals antedate the Civil War and those in New Orleans and San Francisco, accommodating more than 300 patients each, are frame structures that were erected shortly after the Civil War. At that time hospitals, when fever infected, were designed to be destroyed and replaced at frequent intervals. These hospitals were therefore literally "built to burn." There is an obvious need for new construction to replace obsolete buildings and to increase capacities. At date of present writing 94 per cent of all beds in the marine hospitals are filled, except at the National Leper Home Carville, La., and the hospital on Ellis Island which is reserved chiefly for immigrants; not more than 85 per cent of the rated capacity of a general hospital should be occupied.

As the number and tonnage of its merchant vessels have increased with the growth of the nation, the demand for medical care of beneficiaries has grown. It has trebled since 1915 and doubled since 1918.

With the exception of Marine Hospital No. 9, Fort Stanton, N. Y., which is reserved for selected tuberculous patients, and the National Leper Home, the marine hospitals handle chiefly acute medical and surgical cases.

The average cost per patient per day in marine hospitals for the last fiscal year was \$3.80. This includes all salaries, fees, provisions, supplies, fuel, light, water, upkeep of buildings and ambulance and motor transport service. While this figure is recognized as being too low and, funds permitting, a per diem of not less than \$4 per patient is considered a desirable average, an acceptable standard of hospital care has been furnished and the institutions compare most favorably in character of clinical work, with civilian hospitals in the same localities.

In 1562, Bertrand Le Blas, a gentleman of Holland, who became insane, was given the following humane treatment to rid him of his affliction: "He was dragged on a hurdle, with his mouth bound with an iron gag, to the market place, and there his right hand and foot were burned and twisted off between two red-hot irons, to drive out the evil that was in his mind." How different from the modern treatment of mental disturbances in the up-to-date psychopathic hospital!

*The U. S. Marines, a military corps constituting a part of the U. S. Navy, are, when sick, or disabled, treated in the naval hospitals.

HOW OCCUPATIONAL THERAPY PROMOTES RECOVERY

By Major George F. Lull, M.C., U. S. Army,
Washington, D. C.

THERE has been mention of occupational therapy at various times since 1791, although the practice of supplementing medical and surgical treatment with diversional and curative occupations was not known by that name until December 28, 1914. It was then that Edward Barton, at a conference of hospital workers called by the Massachusetts State Board of Insanity at Boston, used the term. It is now universally applied to that form of remedial treatment consisting of various types of activity, either mental or physical, that relieves a patient temporarily or contributes to or hastens recovery from disease or injury.

The fundamental aim of this work is, first of all, curative—to assist in the recovery of the patient and to send him out of the hospital into society to function again as a whole man, physically, socially, educationally and economically.

The World War gave occupational therapy a great impetus. Prior to this period the work at-

tracted comparatively little attention although much that was excellent was being accomplished in many institutions, chiefly those for the mentally ill. At the present time there are over seven hundred hospitals in the United States that are using occupational therapy in some form.

This curative treatment may be applied both directly and indirectly. The direct benefit comes by means of the employment of various tools, machines or equipment so adjusted or arranged that the patient may derive the maximum benefit from their use. Through prescribed and supervised exercise he may overcome or improve such conditions as are found in muscles that are fibrosed or partially paralyzed, in joints that are diseased or injured, resulting in stiffness and limitation of motion, and in nerves needing regeneration. Most of this special curative treatment, from the graduated use of the larger and more complex equipment, is administered best in the curative workshops, although much may be accomplished



The pottery shop is an excellent place for work that exercises the hands and fingers.



Patients preparing miscellaneous articles in the art shop. Much of this work may be done with inexpensive equipment.

with simple equipment in the wards before the patient is able to go to these shops.

The indirect benefit comes from a contented or improved mental attitude, which usually results from some harmonious mental activity that, in many cases, may be combined with physical, constructive activity in producing some material product. This favorable mental state is recognized as conducive to a more rapid recovery in practically every case of disease or injury.

Medical men realize more and more the power of the mind over the body and the difficulty of trying to cure one without considering the other. Why is depressing conversation at the table discouraged? Why does one not have much appetite, or eat well, or enjoy food if he has had bad news or is afflicted with a fit of anger?

In the selection of occupational therapy it is important to fit the activity to the needs of the patient, this being controlled largely by the patient's physical and mental condition, mental capacity and interest, and the equipment and materials available. Much of the therapeutic value of occupation is due to the response the patient makes through this quality of interest. The pleasure derived from the constructive, creative element involved constitutes the greatest part of the treatment for the largest number of patients. As far as possible the choice of activity is left to the patient, although it is necessary in some cases to act only on the advice of the doctor. It is for the therapist to present an occupation that meets the patient's needs in such a way as to cause him to feel he has made the choice of his own accord. Of two activities of equal interest to him it is preferable to encourage that which will supply not only an immediate therapeutic value but will also be of some future use.

It is desirable to combine certain academic or commercial work with some sort of hand or craft work, one interest relieving the other and thus maintaining a better balance.

Much may be accomplished with equipment that is comparatively simple and inexpensive, and with supplies that may be provided at small cost. In fact, most hospitals have quantities of salvage that may be used to good advantage in occupational work.

Consider first the patient confined to bed or to the ward, although such cases as are acutely ill are not eligible for any activity. Among the types for whom occupational therapy may be used are orthopedic, neurosurgical, general surgical, neuropsychiatric, tuberculous, cardiac, general medical and chronic diseases and disorders of all sorts. Among these are found patients who are excitable,



The vertical loom weaving offers good exercise for weak arms.



Basketry is a popular form of work for men.

exacting, abusive and stubborn. Some are resistive, demanding and willful, unreasonable and uncooperative. Others are depressed, retarded, undecided and doubtful. A number are morbid, self-satisfied, spineless and lazy. For these varying types, as far as possible, a general survey is made. Then some occupation is given to supply self-administered treatment, or a treatment in which the patient willingly takes an active part.

It is difficult to meet the needs of some of these patients with the available equipment and materials, but the ingenious therapist must apply her knowledge of psychology and develop, if necessary, the proper interest in something she can supply. Found valuable for these patients are reading, writing, the radio, music, games and other recreation, academic and commercial subjects, limited work with flowers, and much hand and craft work. These are suitable both in simplicity and com-

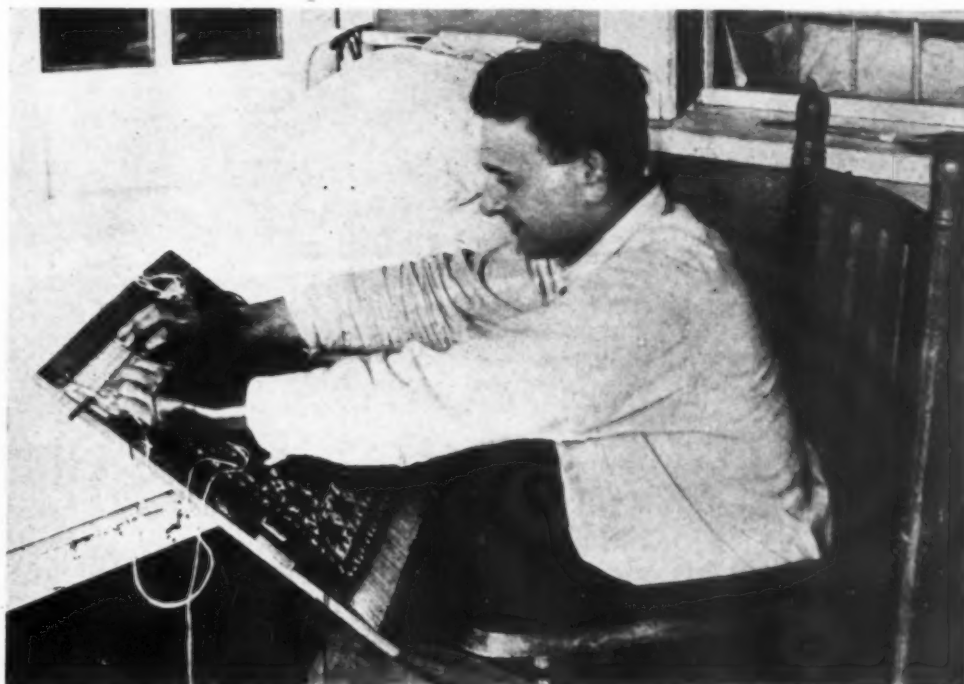
plexity to meet the endless demands of the wide variety of patients in the general hospital.

At very little cost for either equipment or supplies much may be done for the patient needing and desiring elementary educational work. Such subjects as English, history, spelling, arithmetic, writing, citizenship, Americanization work, and simple commercial subjects, including typing, shorthand and bookkeeping supply an excellent and valuable field from which the patient may choose.

Among the handwork and craft subjects are needlework, knitting, crocheting, braiding, reed and raffia basketry, pine needle work, whittling, woodcarving, drawing, designing, painting, stenciling, block printing, modeling, gesso, simple jewelry and metal work, simple woodwork and toy making, leather work, dyeing and simple weaving.

For the patient who has lost an arm it is important that he train the other to be as useful as conditions will permit, or, if he is using some prosthesis, to assist in developing skillful manipulation of it.

As the patient improves he should be encouraged or required to leave the ward and go into some new environment. For many, occupation in the form of outdoor exercise is a wholesome employment. Walking, outdoor games and work in the gardens contribute materially to the patient's improvement. For some there are excursions to museums, art galleries, parks and places of general interest. Others may go to the classroom or shop where there should be more complete and elaborate equipment and an atmosphere differing from that of the ward. Here the patient's work



Rug and other kinds of weaving is done extensively on the wards.

may be increased, if his condition permits, both in mental and physical requirements until the maximum amount of improvement is reached. In the shop he becomes a member of a social group and learns to react much as he would when adjusting himself normally in the social world.

For the curative case requiring special exercise, information is given as to the kinds of work that will supply this, and the patient is allowed to choose that which he prefers. In this way there is not only the curative exercise but the mental stimulus and interest through which an end product of real value is produced, this, of course, being of secondary consideration. There may be adapted, as needed, special handles, treadles and adjustable seats for tools and machines. The post drill may be fitted with a hand device, thus allowing the patient to flex and extend the shoulder; foot power saws may be fitted with wedge-shaped blocks that maintain the foot in a dorsiflexed position; looms may be fitted with beaters hung at angles accessible to elbows with stiffened joints, or otherwise limited in range of motion. The warp of the tapestry loom may be loosened to conform to the limitation of fingers weakened by arthritis. As a patient works his way gradually back to strength, adjustment of equipment is made accordingly, until the patient may use tools requiring normal handling.

Curative and Restorative Work

At the same time the patient is receiving curative work as applied to functional restoration of disabled joints, muscles and nerves, he is also improving his education so that when the time for full or partial social and economic adjustment arrives he is better able to meet the situation. If the patient cannot return to his former occupation there may be opportunity to discover a new field in which he is interested and for which he is mentally and physically capable of taking training. When feasible, preparatory work is started while he is receiving treatment. If he happens to be a patient requiring a long period of hospitalization he may become so proficient in some line that he will need no further preparation upon leaving the hospital.

As to the quality of workmanship, the patient is considered first and, while the aim is for excellence, sometimes the making of an inferior article will have the same therapeutic effect as the completion of a perfect one. The therapeutic value is often commensurate with the quality of the work. It is very important that patients do not over-exercise and delay recovery instead of hastening it.

Material for craft work may be supplied to the

patient in a number of different ways. If the hospital can afford it, a part or all of the material may be given to the patient as a part of his treatment, the finished product belonging to him to dispose of as he wishes. This method relieves a certain class of patients of the worry connected with the expenditure of funds already depleted incident to their illness. Unfortunately, this procedure is impossible in many hospitals, because of its cost. In this case, the patient may be charged the cost price of the material, this amount to be repaid either by the sale of the finished article, or, of two articles made, one may be retained by the patient and the other sold by the hospital.

Commercial Side Secondary

Although the commercial side of the work should be secondary, the patient's convalescence is not aided by financial worries, no matter how trivial, and the small income gained from the sale of completed articles may cause the patient a degree of mental ease. To the permanently handicapped the intelligent application of craft work learned in hospital may result in a means of livelihood after they are discharged.

Many hospitals make the mistake of selecting a dark basement room for a workshop. The occupational therapy shop should be bright, cheerful and easily accessible. The individual reacts to a certain extent to his surroundings, and a dull, poorly ventilated and poorly lighted room has a depressing effect on both patients and personnel.

The library is a valuable adjunct to the occupational therapy department. Many patients, whose illness does not prevent their reading, would rather read than do craft work. The library to be of any benefit should be accessible to the patient. At the Walter Reed General Hospital, Washington, D. C., in addition to a centrally located library, bookcarts stocked with a selection of various kinds of literature are taken through the wards at frequent intervals, so that the patient comes in contact with the librarians and may make known his wants.

The coordination of medical social service and occupational therapy is of the greatest advantage. The aid in her contact with the patient very often learns of things that can be adjusted by the social service worker. On the other hand, the social worker may aid the patient in becoming interested in some form of creative endeavor.

The selection of the aid is of the utmost importance. She must have an agreeable and pleasing personality, and be able to approach the patient in an intelligent manner. If she is unable to do this her work will meet with but slight success. She must be able to cooperate with doctors, nurses,

and other hospital personnel, as working at odds with these individuals will result in failure. There are many persons who go to the work poorly trained, who can see only the results brought about by the making of some article of craft work and who lose sight of the broader meaning of occupational therapy. There are now in the country a number of well recognized schools of occupational therapy that train aids for this work.

At the Walter Reed General Hospital a special training course of six months is given to selected graduates of recognized schools of occupational therapy who have had in addition the equivalent of one year's college work. In this course the students are taught not only the practical side of occupational therapy, including advanced courses in the crafts and allied occupational subjects, but also the theoretical side with a view always to the medical application of the work. Walter Reed General Hospital is especially well equipped to give the students a broad vision of occupational therapy because it is a large and a general hospital and can give comprehensive and diversified training.

This valuable adjunct to medical and surgical treatment may be started on a small scale with little expenditure of funds, and developed gradually if the results warrant development. Even in the small community hospital, where most of the cases are discharged as soon as possible, there is a field for the work during early convalescence, and, if there are facilities for doing so, the work may be continued in the home of the patient.

HOW CAN THE TURNOVER IN PERSONNEL BE LESSENE?

By Margaret J. Robinson, R.N., Superintendent,
Montefiore Hospital,
Pittsburgh

The turnover of hospital personnel has been a live study ever since hospitals have come to realize its importance in keeping up the morale of an institution and the very definite effect it produces on the hospital budget and balance sheet. Many remedies have been suggested and recently very definite statistics have been produced by hospital economists as to the cost of this turnover to the hospital.

Again, it involves consideration of everyone on the payroll—professional, clerical, mechanical, housekeeping and on down to the lower grades of common labor. Each of these departments has its complex problems to meet because of too much turnover and all of their problems affect the economic balance at the end of the month.

It occurs to me that of first importance is the question of selection. Too often the hospital administrator and department head choose personnel to meet the emergency without taking time to study the individual's qualifications or the possibilities of his keeping the job long enough to become properly oriented and a unit of value in the hospital service worth the wages the job pays.

Considering selection as the point of first importance,

the second point, of course, is the regulation of salaries and wages according to the rates paid by other institutions in the same locality insofar as the hospital's finances will permit. In other words, if a hospital pays its graduate nurse supervisors only \$85 per month when other hospitals in the same city pay \$95 to \$100 per month for the corresponding position, it stands to reason that the graduate nurse is going to move as soon as a better job is available for a better salary in the same locality. This will prove the same for any other position on the pay roll.

If, on the other hand, no prospect of reward is held out to either the professional or other worker for continued service, such as a sliding scale according to length of service, then the employee naturally will be attracted to other institutions that show more appreciation of continued service. Such an arrangement should be very definite. There can be no more dangerous policy that will adversely affect the morale of the institution than to allow raises on demand or because the individual thinks himself entitled to it. If an administrator permits himself to do this the obsession of importance in the individual and the demand for greater salary filters through the institution like an acute infection.

The third consideration of importance governing the turnover is naturally the questions of food and living conditions. This applies to all classes of help on the pay roll and includes the giving of the best that is possible in interns' quarters, nurses' homes, and service buildings for the lower grades of help.

On the food question volumes can be written. At a recent conference of superintendents in a city of 650,000, the representatives of only one hospital ventured to say that the interns did not complain of their food, and she attributed this to the fact that for many years one of the Sisters had been giving personal attention to promoting the comfort of the house staff.

Hospitals where nurses do not complain of the food and where the lower grades of help do not complain are few. Few of us have money enough to give *de luxe* menus to our personnel, but I think we are all coming to realize what a big factor the food question is in the labor turnover and are trying our best to meet it.

Personal touch and the human interest element comes largely into the labor turnover problem, just the same as it does in everything else about a hospital plant. Wherever the supervising officer and department heads can skillfully and kindly give correction and encouragement the labor turnover automatically decreases.

EASTERN SECTION OF SANATORIUM ASSOCIATION MEETS

Dr. Frederick H. C. Heise, Trudeau Sanatorium, Trudeau, N. Y., was elected president of the Eastern Section of the American Sanatorium Association at its annual meeting held at the New Jersey Sanatorium for Tuberculous Diseases, Glen Gardner, N. J. and at the Essex Mountain Sanatorium, Verona, N. Y., November 13. The other officers are Dr. Hugh B. Campbell, medical director, Norwich State Tuberculosis Sanatorium, Norwich, Conn., vice-president, and Dr. E. B. Emerson, medical director, Massachusetts State Tuberculosis Sanatorium, Rutland, Mass., secretary treasurer.

Some of the addresses of the meeting were "Latent Tuberculous Infection and its Relation to Pulmonary Tuberculosis," by Dr. Eugene L. Opie, Philadelphia; "Physics and Therapeutics of Light with a Plea for its More Extensive Use," by Dr. Edgar Mayer, Saranac Lake, N. Y.

THE OUTLOOK FOR NURSING IN 1926 WITH A BRIEF REVIEW OF 1925

By Laura R. Logan, R. N., Dean, Illinois Training School for Nurses,
Chicago

FORECASTING growth possibilities for nursing in the coming year with any degree of certainty is obviously an unequal task. The editor of *THE MODERN HOSPITAL*, however, has faith in the idea that if the plans and purposes of nursing groups and the trends of their interests and undertakings are clarified and made public, greater general cooperation will result.

Moreover, certain lines of progress made in 1925, such as increase in number of applicants to training schools for nurses, and increased preliminary preparation represented by these applicants, are sure to continue in 1926. It can also be predicted that in the next few years the curricula for undergraduate nurses will more generally include courses in public health nursing, and that both the training and education of the public health nurse will be begun in the undergraduate hospital course.

Besides the study undertaken by the National League of Nursing Education¹ Massachusetts reports several studies in progress of out-patient departments with reference to the educational value of the work of the student nurse. Readers are referred especially to two papers, one by Effie J. Taylor, associate professor of nursing, Yale University School of Nursing, New Haven, Conn., "Should the Fundamentals of Public Health Nursing Be Taught to the Student?" in *THE MODERN HOSPITAL* for October, 1925, and one by Howard Childs Carpenter, M.D., Children's Hospital, Philadelphia, "The Responsibility of the Hospital in the Prevention of Disease," in *THE MODERN HOSPITAL* for December, 1925. Dr. Carpenter states: "Today the public health nurse is our greatest instrument in preventive medicine." This growing

tendency is a matter of special gratification to the writer of this review, who introduced courses in preventive medicine and public health, both as separate undergraduate courses and as integral parts of the nursing course in the undergraduate program of the School of Nursing and Health, University of Cincinnati, some nine years ago.²

One sociologist has said: "Nurses stand on the firing line of life and of social problems. Few others do so in a like sense." . . . "Nurses are

where life conditions and problems issue in incapacity, or even in death." "Nurses are where all evils in individual and social, in business and moral and political life 'come home to roost.' Sickneses are veritable exhibits of the social state; a hospital is a sociological laboratory; more even than jails, almshouses, courts, are the hospital and the sick room social. What nurses see there tells of individual, social, community and civic conditions. For probably some 3,000,000 are ill at any given

The Public's Need

IN PREPARING a forecast of nursing one thinks at once of community need, and a survey of that need and of the registries operated by the nurses of the country shows that the public will not be satisfied by the lowering of educational and professional standards but demands the most intelligent and sympathetic care it is possible to procure.

The work that is being undertaken in the various states by the nurses of the country shows a growing knowledge of the public's need and of the sociological principles and economic conditions underlying the service they are called to perform.

time, and the average person has 'sick leave' from routine life for probably two weeks each year. The social significance of the nurse's locus of work is very inclusive. To teach her to see it so and to endeavor to function in response to that insight would elevate the profession to a new level rightly belonging to it."

For more than twenty years the nurses of the country have turned to the making of registration laws regulating the practice of nursing and by this avenue of legislation, as well as by other methods, have sought to raise entrance standards and reconstruct the curriculum, in the belief that the better the preparation of the nurse the more adequate would be her service to the community.

Texas reports that the compulsory registration

1. "The Pupil Nurse in the Out-Patient Department," Committee on Dispensary Development, 370 Seventh Ave., New York.

2. Educational Obligations, Laura R. Logan, American Journal of Nursing, Vol. 17, July, 1917.

law as passed two years ago, continues to operate and is improving markedly the work of its registered schools of nursing. Its examining board has authority to determine what shall constitute an accredited school of nursing.

Several of our states have recently passed such revisions of their registration laws as will function to further the protection of the public from poorly prepared nurses.

Virginia's nurse registration law this year provides for increased minimum educational entrance requirements to two years from an accredited high school. Credentials are sent to the state examiners for approval before the acceptance of a student into a school. Virginia has also standardized its records in schools of nursing this year through the effort of the state board of nurse examiners.

The nurses of Missouri entered for the third time upon a legislative struggle during 1925 and finally met with success. They have raised the admission standards from eighth grade to completion of one year of high school.

Idaho and Colorado as well as Virginia have raised their entrance standards from one to two years of high school this year.

Of the five states—South Carolina, North Dakota, Alabama, Minnesota and Michigan—which the digest of laws of states requiring registration for nurses and attendants issued by the American Nurses' Association in 1924 reported as having only eighth grade admission standards for entrance to schools of nursing, two, Alabama and North Dakota, report plans to raise this standard in 1926. In 1925 North Dakota sought among other legislative improvements a two years' high school entrance standard. The bill was lost. They plan to introduce a similar bill in 1926. The senate of North Dakota passed the bill in 1925.

Alabama Plans to Raise Requirements

Alabama plans to seek through legislation in 1926 to raise the entrance requirements from eighth grade to at least one year of high school. This state also seeks to raise the bed requirement of a hospital maintaining a school of nursing from the meager experience provided by twenty beds, most of which are surgical. Alabama nurses are backed in this effort by the best medical men of the state and one can almost predict a greatly improved registration law that will operate for the protection and better care of Alabama's sick in the near future.

The nurses of North Dakota backed a bill providing for the better care of tuberculous children. This was passed and a preventorium will be built the coming year.

Vermont nurses plan to amend and strengthen

their registration law during the year 1926.

Pennsylvania reports the formation of a committee on legislation to make definite changes in the nurse bill of 1926 and 1927. The changes will include a clause governing the standards of preliminary education for admission to training schools and will provide for universal licensing and for an additional educational director. Pennsylvania public health nursing work is increasing its many ramifications.

Washington, D. C., Philadelphia, Milwaukee and Woburn, Mass., are continuing experiments in centralized teaching for nursing schools. Philadelphia reports that the central school is now self-supporting and is meeting with favor in new hospitals; Washington reports that better prepared applicants are applying to the centralized school of nursing at George Washington University, which is receiving the cooperation of the faculty.

Three States With Nurse Practice Laws

We quote here the interesting figures furnished by three of the states that have nurse practice laws providing standards that operate for the growth of the profession and the protection of the public, and that are put into operation through a provision in the law for an educational director or secretary or state inspector. These figures will enable the reader to make his own forecast for 1926 in these as well as in other states providing such directors and such laws.

In Ohio 60 per cent of the schools of nursing affiliate for clinical and theoretical work in additional services, including communicable, psychiatric, medical, obstetrical, pediatric and tuberculosis services.

In addition to good state inspection and nurse practice law, Ohio has three university schools of nursing and it has far-seeing plans for the working out of the state public health program as a whole.

Ohio illustrates, as do New York, Wisconsin and other states, that high admission standards draw more and better students.

Preliminary education certificates issued in Ohio to prospective students from July 1 to November 1, 1925, number 989. Of these students 695 or 70.2 per cent were graduates from a first grade high school with fifteen units. This is really a most remarkable showing.

During the same five months in 1924, there were 939 certificates issued and 69.3 per cent were of fifteen unit evaluation. Increase in the supply of students in Ohio schools is evident, for in the first ten months of 1923, 1924 and 1925 preliminary certificates were issued as follows: 1923,

1184 certificates; 1924, 1562 certificates, and 1925, 1692 certificates.

New York State Education Department figures for nursing show that "the increase of students entering with four years of high school work is 5 per cent, with two to three years of high school, 6 per cent, making a total gain of 11 per cent of students entering our schools with higher educational credentials than heretofore."

The number of students entering the nursing schools each year has increased from 1,624 in 1920 to 3,641 in 1925, an increase of approximately 55 per cent. In 1914 there were 3,976 students enrolled in New York State's registered schools. In 1925 there were 6,118 students enrolled in New York State's registered schools.

The New York report further states: "The clinical facilities in the registered nurse schools have been very much strengthened through the establishment of affiliations. Two hundred and fifty-eight affiliations have been arranged for one hundred and forty-two schools."

Data From Wisconsin Schools

Figures from Wisconsin that give us a basis for prediction are as follows:

The full number of students in accredited schools in 1924 is 1,195. The total number of students admitted to schools of nursing since July 1925 is 672, of which only 1 per cent have as little as one year of high school. The following analysis shows that 62 per cent of all students in all schools in July 1925 were high school graduates and 76 per cent entering since July 1925 are high school graduates. This is a remarkable and encouraging fact.

Five per cent of the students in the schools in July, 1925, had a one year high school equipment and only 1 per cent of the students entering since July 1925 have as little as one year high school equipment.

Space does not permit the quoting of figures from other states. It is safe to predict an equal growth in 1926, especially in those states that have secured nurse practice acts providing the direction and advice offered by a state director of nursing education whose preparation and experience is adequate for so responsible a position.

Among other states reporting a decided improvement in the educational preparation of students entering schools of nursing are California, Colorado, Louisiana and Texas. Pennsylvania reports a larger number of students in the schools than ever before and the schools in the city of Philadelphia are raising their educational entrance standards.

Besides the above constructive legislation for

safeguarding the professional preparation of the nurse, legislative enactment of a slightly different nature but with the same fundamental end in view has been brought about or is planned through the efforts of the nurses of the various states.

In California a bill was passed last year providing for a foundation in nursing. This will be established in the University of California during the coming year and the professor will be appointed in time to give a summer course. The funds necessary were provided by the state legislature appropriating for this purpose the surplus funds from the receipts of the bureau of registration. Let us hope that California's lead will be followed by other states during the coming year.

The nurses of Georgia have made preliminary plans for including the preparation of the leaders in nursing in the work of Emory University, Emory University, Ga.

The nurses of Kansas are planning to effect in 1926 or 1927 the passage of a law that will establish a department of nursing in the state university and will also subsidize the colleges in various districts of the states, to the end that these colleges may carry, through affiliation, the teaching of the basic sciences for the hospital schools of nursing in these districts. The interest and support of the leading health authorities and physicians of the state and the sympathy of the governor and other important and public-spirited citizens in this plan, promise definite accomplishment for Kansas in the very near future if not in 1926.

Progress in Accommodations

In a number of other states progress is indicated by the better accommodations and classrooms afforded the student nurse. Rhode Island reports an addition to the Rhode Island Hospital Nurses' Home, Providence, which gives a whole floor over to classrooms. Illinois has an unusual record for 1925. It reports the opening of a beautiful residence at the Michael Reese School of Nursing, Chicago, equipped with classrooms and laboratories of a high order; with new building at St. Luke's Hospital, Chicago, the school of nursing therein receives the impetus that new and well equipped classrooms cannot fail to bring.

The Grant Hospital, Chicago, also has a new school of nursing and a residence building opened in 1925.

In hospitals everywhere new buildings are going up, affording improved facilities for the care of the sick, which will make better nursing possible. There are those of the Vanderbilt Medical School and Hospital, Nashville, Tenn., the Strong

Memorial Hospital, Rochester, N. Y., the new Presbyterian buildings in New York. The University of Illinois is completing a series of splendid hospital buildings, and in 1926 the new Billings Memorial Hospital on the University of Chicago campus will be completed.

The Cook County Hospital, Chicago, will complete in 1926 a new medical building, a receiving building and a modern, completely equipped children's hospital of 500 beds. This hospital will care for all types of children's diseases and will make possible excellent facilities for postgraduate and affiliated nursing courses in children's diseases. These will include public health work with children made possible by the large clinics and dispensaries in this hospital.

At least the following states—California, Illinois, Michigan, Massachusetts, New York, North Carolina, Missouri, Ohio, Pennsylvania, Tennessee, Washington and Wisconsin—have held institutes during the year under the auspices of the state leagues of nursing education and Wisconsin under the auspices of the Wisconsin Anti-Tuberculosis Association. Next year California, Illinois, Louisiana, Massachusetts, Pennsylvania, Wisconsin and others will again hold institutes. These are bound to stimulate enrollment in summer courses and registration in colleges and universities, where courses taken will bring the nurse back to active service, able to do a better piece of work and to assume larger responsibilities.

Events of signal importance that have occurred during the year are the opening of the school of nursing at the University of Rochester, Rochester, N. Y., Helen Wood as director, and an endowment from the Rockefeller Foundation to the Vanderbilt University, Nashville, Tenn., for a school of nursing.

Plans for University Affiliation

Besides these, perhaps the most prophetic happenings of 1925 are the plans laid and the arrangements effected for university or college affiliation for schools of nursing in hospitals throughout the country.

Two hospital schools of nursing in California, one in Riverside and one in Pasadena, have effected an affiliation with the Riverside Junior College, on a most interesting, modified cooperative plan of education similar to that begun in the University of Cincinnati and later copied at Antioch College, Yellow Springs, Ohio.

The University of Washington, Seattle, Wash., affiliates with local Seattle schools for the teaching of the basic sciences. The members of the university faculty have shown much interest in the plan and have asked that in 1926 more time

be allowed for the university courses by the hospitals, so that well rounded elementary courses may be given and at least the fundamental concepts of the subjects assigned to them. This insistence upon full time university courses is one of the most hopeful indications for future developments in nursing education.

In Arkansas three of the Faulkner county schools have affiliated with the state teachers college for the teaching of basic sciences and there is a plan to include more of the hospital schools of nursing in 1926. This arrangement will place these schools under the supervision of the state department of education. An appeal to the State University of Arkansas for admission for courses was refused owing to lack of university funds and facilities.

The Rhode Island Hospital School of Nursing students are receiving their instruction in bacteriology at Brown University, Providence, R. I. St. Luke's Hospital, St. Louis, is working for university affiliation in the near future. The Borgess Hospital, Kalamazoo, Mich., is planning to establish a five-year course in affiliation with the Catholic College at Kalamazoo.

Joint Committee of Three Nursing Groups

A joint committee of the three state nursing organizations of Pennsylvania has recently been appointed to study the possibilities of postgraduate courses for nurses in administration, teaching and public health in the universities of Pennsylvania and Pittsburgh.

A significant event in the history of nursing was the establishment, through the efforts of the Illinois State League of Nursing Education, of a summer course in 1925 at the University of Chicago, in the College of Arts, Literature and Science. This course was under the direction of Dean Laura R. Logan, Illinois Training School for Nurses, Chicago, who offered two fundamental courses for administrators and teachers. Thirty-eight nurses registered from eight different states and took one or both of the nursing courses and were registered in twelve other departments of the university. The Illinois League has requested the University of Chicago to repeat the summer course again in 1926. Anna D. Wolf, formerly of the school of nursing, Peking Union Medical College Hospital, Peking, China, who has been appointed superintendent of the nursing services of the Billings Memorial Hospital of the University of Chicago, will be in charge of the course next summer. The question of a combined degree and nursing course is also under consideration by the University of Chicago.

The Michigan League of Nursing Education is

planning a summer course for administrators and instructors at the University of Michigan.

The University of Florida, in cooperation with the Florida State Examining Board of Nurses, introduced into its 1925 summer session a course for graduate nurses. Blanche Pfefferkorn, executive secretary, National League of Nursing Education, New York, directed the course. The program included two courses in administration and nursing education and courses in psychology and sociology. A full summer session of eight weeks is planned for the summer of 1926 and will offer a wide range of electives in the various colleges of the university.

Marquette University, Milwaukee, has established a college of hospital administration that is open to nurses interested in this field.

In Massachusetts the league of nursing education is undertaking a study called "The interrelation of the work of the head nurses and supervisor with reference to the best management of the ward and the education of the nurse, with the purpose (1) to stimulate interest in the better care of patients; (2) to compare methods of managing ward situations in various schools for the purpose of improving these methods; (3) to study and recommend ways and means of using clinical material on the ward for the most effective education of the student nurse." General and special hospitals are included in the study.

Many pages could be written about other constructive work of the national, state and local nursing organizations, of programs for public health, and of the grading program for schools of nursing, the plans for which will doubtless be under way in 1926.

During the year the Red Cross public health nurses have visited 1,099,492 homes and 83,348 schools and have inspected 1,473,031 children. These figures give some indication of what this work will continue to mean to public health. The itinerant nursing work is to be extended to the eastern and Pacific areas this year.

The Government nursing services are keeping pace with and often exceeding the state or privately financed parallel enterprises. The United States Veterans' Bureau finds the medical council and the nursing advisory committee of real assistance in advancing its program.

One thing is assured—the loyalty and preparedness of the nursing profession. This was signified in its response on National Defense Day, September 2, 1924, when 24,916 Red Cross nurses responded to the roll call of the National Red Cross Nursing Service, issued by Clara D. Noyes, its director.

MEDICAL SOCIAL SERVICE WORK AND LOCAL AGENCIES

Where there is no social service department in a hospital, the local family welfare agency may handle some of the medical social service, according to Clarence King, secretary, Bridgeport Financial Federation, Bridgeport, Conn., in answer to the questions, "What part of medical social service work can be handled by local social agencies? What should be the relation of the local social agencies to the social service department of the hospital?"

"Particularly in a community chest city, a social service department is desirable, because through it many misunderstandings can be straightened out," he says.

"Factory workers, particularly, are prone to believe that because they have given a dollar to the community chest, they should have free treatment in the hospital wards. Resentment arises from vigorous efforts to collect hospital bills. A social service department will furnish the hospital with facts with reference to the economic conditions of ward patients. This information is invaluable from the standpoint of the hospital in collecting its bill and the community chest in allaying misunderstandings and hard feelings."

SHOULD COUNTY HOSPITALS ADMIT PAY PATIENTS?

That municipal and county hospitals should provide for part-pay patients is the opinion expressed by Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, in discussing the responsibilities of the public and county hospital.

The person who can pay only part of his hospital charge is, in Dr. Munger's opinion, just as much entitled to assistance from public funds as is the man who can pay nothing. If the municipality has an established hospital, it would seem unwise, he says, for it to send its pay-patients elsewhere.

He also believes that within limits the public hospitals should accept pay patients. In most cities and counties the public hospital is still the only one that will maintain wards for venereal diseases, contagion, tuberculosis, and mental cases. It would surely be wrong, he thinks, to deprive any person desiring treatment in these wards of the privileges of coming to the hospital. On the other hand, it would be equally wrong to admit all such persons and charge them nothing, even though they could pay.

DECORATING WICKER FURNITURE

The house painter in a large Eastern sanitarium has found a quick and inexpensive way to refinish the wicker furniture that is used on the porches, the sun parlors and in some of the meeting rooms. These are painted with a hand sprayer of the kind used in gardens and for insects. The first coat of enamel is put on by hand and the polychrome effect is obtained by splashing with gold over the coat of deep blue enamel paint.

The steward of a New York hospital finds that the best lubricant for kitchen equipment, where food is apt to come in contact with the working parts, is plain olive oil or mineral oil.

In the year 1006 the Venetian Republic possessed a hospital of large proportions. In 1173 the Christians in Jerusalem had one for the use of their own sick and infirm.

WHAT THE DIETITIAN HAS DONE AND WILL DO

By Rena S. Eckman, Director of Dietetics, Michael Reese Hospital,
Chicago

A REVIEW of the work of dietitians cannot properly begin without mention of some of the factors that led to the development of this profession which aims to foster the physical well-being of human beings and to aid in the salvage of lives that have met with disaster.

It has been said recently by a prominent physician that the hospital was at first a sort of almshouse or hotel for sick people, that in some way evolved out of the philanthropy of good Samaritans upon whose generosity in olden times the sick traveler or homeless sufferer depended for his life and comfort.

The development of the community conscience brought forth the realization that the rehabilitation of the sick, needy and injured was a service to the state. The hospital in its present mode of operation is the result of the promulgation of this idea. In time physicians discovered that the hospital could be so organized as to serve in an educational capacity, enabling the young physician to observe and to obtain practice in treating many forms of disease that he otherwise might not encounter in a lifetime. By this means he could enlarge his experience and enhance his value to the profession as well as to humanity.

And then physicians came to realize that without nursing care much of their labor was unavailing; following this, the profession of nursing came into its own and advanced rapidly to its present high state of perfection.

Just as the progress of the sciences made possible the application of their laws to the treatment of disease, so it also showed the necessity for developing more specialized fields within the hospital. In consequence of this, that institution became an aggregation of units devoted to the study and treatment of different conditions. Hence we find internal medicine, pediatrics, electrotherapeutics, surgery in its different branches, chemis-

try, and bacteriology as different departments of a hospital.

With the nursing field, which made hospital treatment a possibility, dietetics was first associated. The hospital was thus enabled to bring a new intelligence to its aid—that which was conceived, fostered and developed by the home economics movement which had followed in the wake of the rapidly developing sciences, notably the chemistry and physiology of plant and animal life, culminating, for the dietitian, in the science of food and nutrition.

By means of dietetics much of the hospital treatment of today is greatly enhanced and facilitated.

From time to time inquiries are made as to the work of a dietitian, her qualifications, her training, her place in the hospital, her position on the administrative staff, her power to cooperate with physicians, and, last but not least, her future. I have been asked to comment upon these subjects.

In the educational world about twenty-five years ago, there came a demand for the teaching of manual arts in the primary and secondary schools. This resolved itself into the teaching of hand and tool work of various sorts to boys, while girls were required to learn sewing and cooking. In high schools and colleges, arts and sciences were introduced.

Normal schools as a result of this movement found it necessary to train teachers to teach these subjects. This training embraced the usual pedagogical and academic requirements but modified some of the courses in order to make them apply specifically to the subject in hand. Chemistry, for instance, involved the processes of cooking and cleaning as applied to household needs, the manufacture and care of textiles, the chemical composition of foods, the chemistry of nutrition and the profound biological chemistry of the animate world, from microbiology to the life processes of the higher plants and animals.

The Newer Knowledge

SUCH has been the progress of investigations along the line of biological science and the chemistry of food and nutrition in normal and abnormal conditions, that constant attention must be paid to the world of science in order to take advantage of the newer knowledge of nutrition that is being brought to us. Theories are constantly being substantiated by facts that are brought to light, and today we are continually on tiptoe looking for the next news that may come from Toronto or New Haven or Boston, New York, Chicago, Baltimore or the West, even to the Golden Gate and its farther shores.

Women who first entered hospitals as dietitians came from schools that gave training along the above lines. Many of these women found their training entirely adequate, enabling them to perform the duties assigned to them by the hospital, and this condition obtained for several years. From the beginning the dietitian was required to be an instructor of student nurses, mainly in invalid cookery. Since that function did not occupy all of her time she was required to assume other duties, often of a housekeeping nature.

Close Relationship With Nursing

Adelaide Nutting was one of the first to realize that women were being instructed and trained in the household arts and sciences as indicated above. She conceived the idea of profiting by the knowledge these women possessed and employed one of them to instruct the student nurses of Johns Hopkins Hospital, Baltimore, Md., in the preparation of food for invalids. As much of their time as was not needed for that purpose was to be devoted to the oversight of the housekeeping of the nurses' residence. In a short time this dietitian came to be regarded as indispensable. Other hospitals learned of the venture and promptly followed suit, also employing dietitians. More and more responsibility gravitated to these women, for the management of the hospital began to see that much gain resulted to the hospital from the contributions of these trained women. Before long dietitians were found in other hospitals in New York, Boston, and Philadelphia, doing executive dietary work but also continuing in the capacity of instructor of nurses in invalid cookery.

Each year the knowledge of the value of food to the body became more closely related to the treatment of disease, and required classifications of diets were worked out, suitable to different states of digestion and metabolism. It was the dietitian's duty to interpret these food specifications to her pupils and to see that the preparation of food was suitable for the patients' needs and that the transportation of food to its destination was successfully carried out.

As the scope of the hospital dietitian's work became known to home economists and the demand for women educated in this way increased, the schools of household arts and science found it necessary to enlarge and modify their curriculum in order to give adequate training for the new vocation.

In the meantime scientific literature increased enormously. Every little while a new magazine came into existence, devoted to some phase of medicine or biological science. Many scientific magazines already current gave more and more

space to food and nutrition, until articles on this subject ceased to look strange or out of place among either medical or chemical literature. Universities and colleges, one after another now began to provide the means for carrying on earnest study and research in plant, animal and human nutrition.

Referring now to nutrition and its influence upon life in general, we find that our knowledge pertaining to that subject has come not only from physicians but from men and women who devote themselves to making research possible and who are constantly engaged in research, notably in university nutrition laboratories or in the best hospitals allied with universities. It seemed as if the world was clamoring for the dietitian, trained fully, able, ready and willing to step in and solve all of the many problems presented.

In the joy of having the need of a new activity recognized, the sordid facts of ways and means were half forgotten and only partly planned for. It is not surprising that the questions referred to in the beginning of this article began to be asked. As it were, castles in the air had been built and the foundations necessary for earthly mortals to stand on and to occupy were inadequate. But Ralph Waldo Emerson consoles us by saying that castles should be in the air and we can still put the foundations under them. The questions so often raised refer to these foundations.

The Dietitian's Place in the Hospital

We have already discoursed upon the training that a dietitian needs. How shall we answer the next question, namely, what is to be her place in the hospital? Wisdom assigns a dignified status to her. There are reasons for this. She plays an important role in at least two phases of hospital life. Her department involves the expenditure of a large part of the hospital income and one who bears this responsibility should not be deterred from spending it wisely. Women in the commercial world have proved themselves capable of all the managerial phases of the dietary problem, even to the extent of acquiring a national reputation for efficiency. While all dietitians do not care for administration there are many who do and who function efficiently as soon as the status allotted to them permits them to do so. The other role referred to is the professional one, and certainly it does not need to be argued that if courtesy is due to one profession it is also due to another.

The place of the dietitian is determined also by the type of person who takes up the work. No one should undertake it, and no sensible

woman will, unless she embodies in her character the principles of professional interest, devotion to duty, ambition for a cause and a spirit that aims to give value received in the service she renders. Such a woman can only be classified among the officers of an institution.

The status of the dietitian must continue to be high in rank, for the hospital of the future will need her services more keenly than they now realize. People are beginning to realize the need for proper and adequate nutrition. They must be taught that this subject can be interpreted to them. They must realize that it is no fad and they must know the difference between facts and fads. The public must also know that a busy physician cannot attend to all that the subject involves, and that a specialist is required to look after the intricate details.

Dietitians like to feel that they are of service and aid to physicians. Suitable and well prepared food has always been an aid in the treatment of disease although it has been customary to ignore the service rendered in providing it. In the future there will be no change in this requirement but there will be more specifications just as soon as research and experience furnish the knowledge upon which to authorize them.

Organized Effort for Higher Standards

Physicians and other professions have organized into societies for the pursuance of specific interests and dietitians are already doing the same, realizing the value of concerted effort in clarifying the situations of their field. It is by means of the information dietitians from the field can pool that standards of training for the hospital dietitian can be formulated. Already colleges are known where the curriculum for dietitians is so well planned and the advisory bureau of vocational guidance so efficient that young women sent out from these schools practically never fail to make good in hospital work.

Besides raising the standard of education of dietitians entering the profession there is much other work to be done by an organized body of hospital dietitians. There is always the young person starting in the profession. She has many questions to ask and until recent years did not have a centralized bureau to which she might go for guidance. Suppose it is equipment she desires to investigate. If any officer in the association is unable to direct her to the source of information, that officer will pursue the subject until the information is obtained. Suppose it is costs of various kinds that are in question. Buying, storing and handling of goods are often the responsibility of the dietitian especially in the

smaller hospital; a few institutions have excellent systems in this respect and their methods can be learned upon inquiry.

Perhaps it is the menu that is the mooted question. Helpful suggestions are always available. Perhaps it is the courses of study for pupil nurses or for pupil dietitians. A number of hospitals have given these subjects particular attention and have mapped out excellent courses.

Guidance to the Right Position

Perhaps it is a question of guiding a dietitian into the right sort of position. It has become a rather well-known fact that a number of colleges are keeping their graduates out of hospitals. This is because of the diametrically different views of hospital work entertained by those outside the hospital and those trained to the almost military tactics within the institution. There is work to be done here. Young women should never go directly from college into a hospital position as the transition is too abrupt. A preliminary course as a student dietitian will help to decide whether hospital dietetics is the vocation she is seeking. It also helps her greatly if she does want to go into this field and if she does not want to do so she has by no means wasted her time in taking the course.

Organized dietitians can also help the colleges in planning their curriculum for dietitians, for they can let them know what in the curriculum is most useful, what should be stressed and what touched upon lightly. The dietitian goes back to the college for inspiration and a renewal of her enthusiasm in the work that she is doing and she gets it.

Lastly, organized dietitians can help to further the cause of dietetics by striving to be public spirited and by contributing to the fund of information that is distributed through dietetic magazines.

One of the developments of the last three years has been a magazine for dietitians, "*Dietary Administration and Therapy*," having for its object service to its readers many of whom are dietitians and physicians. Because of the expressions of commendation we have received, we know that the magazine was needed and we know that the world of dietetics will never again be without a magazine of its own.

Among the Christian emperors, Justinianus (527-567) showed the greatest zeal for the establishment of benevolent institutions. In conjunction with his wife, Theodora, he founded in Constantinople and on the road to Jerusalem a number of xenodochia, and bestowed on all these establishments the legal rights of church institutions.

HOW SOCIAL SERVICE SUPPLEMENTS TREATMENT

By Lena R. Waters, Secretary, American Association of Hospital Social Workers,
Chicago

THERE are at the present time approximately 850 social service departments in medical institutions in the United States and Canada, and the rapidly increasing number of new departments far exceeds the supply of personnel with the training considered essential for this special field of social work.

Why has social work become recognized as a necessary part of medical work in institutions? What are social workers doing? How do they fit into the hospital organization? Of what benefit are they to the patients? These and other questions are constantly being asked by those who are faced with the problem of financing hospital activities.

Many developments have led to the conditions that have created the demand for this new feature in the medical world, among them may be mentioned the changes in the industrial world that have attracted to central areas large groups of people and have led to the growth of cities with all their manifold problems. Health workers have been forced to adopt wholesale methods for treating the members of the population and protecting the health of the community. Large dispensaries and hospitals have been organized to partly meet this need.

Progress and Medical Practice

The progress of medical science has meant many changes in the methods of medical practice. Modern medical practice demands specialization and cooperation. There is a renewed recognition of and emphasis on the relationship between personality, environment and disease. Food, rest, sunshine, proper recreation, suitable employment, normal living, are being recognized as of greater importance in treatment than "pills and powders"; without them medical efforts are of no avail.

Many changes have also come about in the organization and conduct of the hospital. In order to meet the needs of medical procedure and the demands of the community, the hospital has far outgrown the old conception of it as a place for the indigent, a shelter for the dying. It is now recognized as the center for the study, treatment and cure of disease, for preventive health activities, for the education of health workers, physicians, nurses, social workers, laboratory workers, dietitians and others engaged in health work.

And so there has been introduced into the medical institution as part of its diagnostic and therapeutic service — social service.

The social service department is an integral part of the hospital, organized, supported and administered as are the other hospital departments. Its services begin with the admission of the patient, continue during diagnosis and treatment and follow the patient after discharge until all has been done to effect as complete a return to normal health and life as is possible. Social service endeavors to make it possible for ev-

Service Needs

IN ORDER that the social service department may function effectively and its workers be of real value, there must be sound and adequate organization. The department must be recognized by the entire hospital personnel as an integral part of the organization. It must have the active cooperation of the chief executive officer and the heads of departments, it must have adequate facilities for its work, including proper offices, records, clerical assistance and, above all, personnel properly educated and trained for this specialty.

Hospital social work is true economy. It means more rapid and more complete treatment for the patient, and it is an important factor in the community's health campaign from a preventive, educational and economic standpoint.

every patient to carry out medical instruction. Its function includes service to patients, education, research, and certain administrative duties that are helpful to the hospital in the maintenance of its community relationships.

It is now very generally recognized that the admitting office is one of the hospital's most important contacts with the public. Certainly the admitting officer is in a strategic position to make the patient's first contact with the dispensary or hospital an encouraging one or the reverse. Here should be gathered information that may have a direct bearing on the treatment and after-care of the patient and should be of value in fixing admission fees and hospital rates. It is generally recognized that admitting is an administrative activity

but that the admitting officer should be a person with training and experience in social work. To quote from a talk given by Edith Howland at the annual meeting of the American Hospital Association in 1924: "The social worker is peculiarly fitted for this admitting work. Her training is supposed to give her a fundamental understanding of life as it must be lived by the great mass of humanity, a knowledge of the causes of the many failures, and of the philosophy underlying the efforts of society to right itself. Her experience has made her familiar with concrete facts concerning social conditions, with actual costs of living, and with the effects of unemployment. Her knowledge of group characteristics and of standards of living, supplies her with a solid basis for decisions concerning financial resources and obligation. She knows the psychology of the approach to a patient, and she knows how to investigate and get at the facts wanted. She is familiar with social organizations, their differentiations, and how to work with them. Her outlook and habit of thought is analytical and interpretive—not emotional. Her method of work is the case work method. She considers the patient as a whole; she has a habit of complete analysis, of splitting up a situation into its elements, and usually sickness is only one of the many problems. She must be a social case worker; she should also have had successful experience in executive work because, by the nature of her position, an admitting officer is an executive."

Social Worker Aids in Diagnosis

The social worker aids in diagnosis by discovering and reporting to the physicians facts regarding the patient's personality and environment, that relate to his physical and mental condition. This includes facts of heredity, personality, habits of life, home and work or school environment, recreation and financial worries.

She aids in treatment and after-care by assisting the patient to adjust his difficulties, by removing obstacles to successful treatment, by arranging for convalescent treatment, by keeping the patient in continued attendance until his complete treatment has been possible, and by vocational and occupational readjustment when his condition indicates the need for it.

Without social service much valuable and expensive medical work is wasted, because of its ineffectiveness. This is true with many children's cases. No greater educational and preventive opportunity exists than work with children. Of what avail is it for the hospital to admit children to its wards, cure them of their ills and return them to the conditions that produced the illness.

The parents must be instructed regarding the causes of the illness, the contributing factors; they must be shown a way to better the conditions and convinced of the necessity of conscientious follow-up treatment to prevent recurrence. The effect of educational work is not confined to the individual child but spreads to the rest of the family and to the relatives and friends, and is a health educational influence in the community. A study of the patients on a children's service in a large city hospital showed conditions unfavorable to convalescence or continued health in 94 per cent of the cases.

Complete Treatment of Tuberculous

No argument is needed for complete treatment for the tuberculous patient. He must have good food, pure air, rest, and freedom from worry. He must not return to a poorly ventilated, overcrowded, unhappy home, or to work that will cause a breakdown. Without the social worker, who in the hospital family is responsible for keeping him in attendance until a diagnosis has been established, for interesting the proper agencies to care for his family when he must temporarily cease being the breadwinner in order to enter a sanatorium? Who will make sure that someone stands ready to help him to find a suitable home and work on his discharge from the sanatorium?

Statistics show that heart disease occurs in one of every fifty of our population. Heart disease kills more people each year than any other single cause. It is preventable, it is often curable, and the patient can usually be helped. A study of the admissions and readmissions of cardiacs to the hospitals of the country would disclose astonishing facts. In making such a study one should consider such points as length of stay on the ward, whether the home conditions were suitable, whether the patient could have been treated successfully at home or in a convalescent home. How much did his treatment cost the hospital? How lasting was the treatment? How many times was he readmitted? What caused the relapses? What did it cost the hospital and how much did it permanently benefit the patient? Social service is doing much to supplement the hospital's treatment of cardiacs, so that the hospital stay may be shortened, the readmissions fewer, and the lasting benefits greater.

There are many needs for social treatment with the surgical group. Convalescent care for the operative cases, continued follow-up for those needing further treatment in the out-patient department, education, vocational training and occupation for those who are permanently handicapped

and crippled. Approximately 225,000 people in the United States are each year severely disabled; 100,000 need rehabilitation to get back on their feet and established in remunerative work. The government, state and private organizations are conducting rehabilitation programs but the first opportunity for help lies with the hospital. The first contact is important. The patient must see a way out before discouragement and demoralization take root. The hospital social worker who is in touch with the outside agencies and who at the same time is one of the medical group within the hospital is the one who can assure a future to the patient and who can smoothly effect a transfer from the medical to the rehabilitation agency.

Some Problems for the Social Worker

In the maternity wards, there is that unfortunately large group of young women, the unmarried mothers. Are they and their babies to be turned out into the unsympathetic world, disgraced, discouraged, penniless and friendless, or does the hospital have a social worker who during the patient's stay in the ward has provided a helping hand for their discharge, either through relatives or through some suitable agency?

The importance of good convalescent treatment is now generally recognized in the medical world. Studies have shown that practically every patient ill enough to require three weeks' care in a hospital for acute diseases, needs an additional three weeks' good convalescent treatment before he is ready for final discharge. Many patients are kept in hospitals for a longer period than is necessary and under conditions not suitable for convalescence, simply because there seems no way to arrange for the convalescent care needed. Or, they may be discharged to homes entirely unsuitable for convalescence, thus delaying the return to health and in some cases undoing the treatment that was given in the hospital. That period between illness and health is one during which the patient needs real guidance. He is neither mentally nor physically able to make the wisest plans for himself, and yet this problem is often treated lightly, with serious after-effect. Social workers are planning for this convalescence from the day the patient enters the hospital. The homes are studied, convalescent institutions are canvassed and a place is ready when the time for discharge from the acute hospital arrives. From a mere financial consideration, hospitals are failing to realize full returns if one considers that the cost of care in a general hospital is about double the cost in a convalescent institution.

Another large group of patients in the hospitals for acute diseases is the group classed as chronics and incurables. These patients are a problem. They do not need the care that this type of hospital provides and yet there so often seems to be no other place for them. Social workers in hospitals throughout the country are making more satisfactory provision for these patients—more satisfactory both from the standpoint of the hospital and of the patient. Several studies of this group of patients have been made. One of them states that in a period of two months in a large city hospital only 38 per cent of a group of patients referred for almshouse care were transferred to the almshouse, suitable provision with relatives, friends and other institutions having been arranged for the rest of those referred. Many cases are known of patients who have for a period of months and even of years been on the wards of acute hospitals who could have, through social service, been transferred to more suitable places, thus releasing the beds for acute cases of typhoid, pneumonia, and other illnesses. Again, from a financial standpoint, the hospital, by quicker transfer of these patients, could have saved more than the salary of a social worker.

The out-patient department of the hospital is its great preventive, educational health opportunity. To this department come the thousands who are in the early stages of illness. Successful treatment here means prevention of more serious illness which too frequently means spread of disease and permanent disability. The social worker finds much need for her service here. She is an intimate part of the clinic team. She learns to know the patients. She knows their background, she makes certain that the physicians' instructions are thoroughly understood, she makes sure that the patients are able to carry out the instructions, and if necessary she finds a way to help them to do this. Through some follow-up plan she insures their regular attendance over a period long enough for complete treatment. When it seems necessary she visits the home, school or employer to discuss with them the patient's condition and to enlist their cooperation in treatment.

Services Needed in All Clinics

There is no clinic of an out-patient department in which her services are not needed. The tuberculous, the orthopedic—with the need for special apparatus, vocational education and convalescent treatment, the cardiac—with its great opportunity for work with children and adolescents, the diabetic clinic with the special diet and the need of constant encouragement, the department of gynecology, with the necessity of long-time treat-

ment for gonorrhea and other problems, the necessary home adjustments for the frightened and overworked mother who must enter the hospital for a serious operation, leaving children and husband at home to shift for themselves—all these departments offer opportunity to the social worker.

There is the syphilis clinic, with its many patients who must be convinced of the necessity of continuing treatment over a long period, and the necessity of bringing in for examination those who have been exposed to infection. Studies have shown that from 40 to 47 per cent of patients diagnosed as syphilitic require follow-up to insure adequate treatment. An efficiency test made of a clinic without a social worker showed that 27 per cent of the syphilitic patients paid only one visit, 15 per cent paid only two visits, 12 per cent only three visits. It is estimated that in 50 per cent of the cases the clinic accomplished little or nothing. In another clinic in the same city where there was a social worker in the clinic 90 per cent of the patients were kept under treatment and the other 10 per cent could be accounted for in various ways.

In addition to the social treatment of the patients, the social worker is constantly alert to opportunities for strengthening the hospital's community relationship. With her community contacts she is in a position to interpret the hospital to the community and the needs of the community to the hospital. She is the liaison between the hospital and the social agencies. She must know how to make available for the patients all the existing agencies of the community. She must not duplicate their work, but should use them as fully as possible to meet the patient's needs.

The social service department, like all other departments, must assist in the education of medical students, student nurses and social workers. It is the responsibility of this department constantly to study the social problems of the hospital and dispensary and to interpret them to the staff and administrators of the institution. The department, through the collection and interpretation of social data, should also assist in medical social research, in learning the social causes and results of disease.

CATHOLIC HOSPITALS OF INDIANA HOLD FOURTH MEETING

The fourth annual meeting of the Indiana Conference of the Catholic Hospital Association, held at St. Mary's Mercy Hospital, Gary, November 24 and 25, was attended by 100 delegates from hospitals of the state. The conference is made up of eighteen Catholic hospitals of Indiana.

The meeting was opened with solemn High Mass with

the Rt. Reverend J. F. Noll, D.D., bishop of Fort Wayne, officiating. The first session was opened with an address of welcome by the Hon. William J. Fulton, mayor of Gary. Response was made by Sister Odilo, St. Joseph's Hospital, Fort Wayne, president of the conference. An expression of welcome on behalf of St. Mary's Mercy Hospital was voiced by Sister Alphonsina, superior. The address of welcome on the part of the medical staff was given by Dr. T. B. Templin.

"Rating of Schools for Nursing Education," was the subject of an address by Sister M. Patricia, La Porte. A discussion of this topic followed by Sister M. Rose, superintendent of nurses, St. Vincent's Hospital, Indianapolis; Sister M. Odilo, superintendent of nurses, St. Joseph's Hospital, Fort Wayne; Sister Florina, superintendent of nurses, St. Margaret's Hospital, Hammond, and Mary Walsh, R.N., instructress of nurses, St. Mary's Mercy Hospital, Gary.

A paper on "Urgent Surgery," was read by Dr. C. C. Robinson, chief surgeon, Illinois Steel Company's Hospital, Gary, and was discussed by a representative from each of the following hospitals: Holy Family, La Porte; St. Vincent's Hospital, Indianapolis, and St. Anthony's Hospital, Terre Haute.

At noon a luncheon was served to the delegates at the hospital, followed by a tour of the city.

Nursing Problems Discussed

The opening address of the afternoon session was on the subject of "Problems of Private Duty Nursing," by the Rev. Edward F. Garesché, S.J., editor, *Hospital Progress*, Milwaukee, Wis. This was discussed by a sister from St. Joseph's Hospital, Mishawaka, a sister from St. Anthony's Hospital, Terre Haute, and nurses from St. Joseph's Hospital, South Bend, St. Vincent's Hospital, Indianapolis, and St. Mary's Hospital, Evansville.

The closing address of the session was given by Dr. E. M. Shanklin, St. Margaret's Hospital, Hammond, who spoke on "The Relation of the Staff to a Catholic Hospital." The subject was discussed by three doctors and two sisters from the following hospitals, respectively, Good Samaritan, Kokomo; St. Francis' Indianapolis, St. Anthony's, Terre Haute.

At six o'clock dinner was served to the clergy and doctors present by the staff of St. Mary's Mercy Hospital, at Lake Front Pavilion. At 7:30 a social hour was held for the sisters and nurses by the sisters and nurses of that hospital.

The program, November 25, was opened with an address by Sister Adolphia, Holy Family Hospital, La Porte, on the subject, "The Importance of Little Things." "A Further Step in Dietetics," was the topic of the paper by Sister Camilliona, St. Elizabeth's Hospital, La Fayette. The paper was discussed by four sisters from the following hospitals, St. Mary's, Evansville; St. John's, Anderson; Sacred Heart, Garrett.

The subject of "Hospital Finance," was presented by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, and was discussed by H. S. Norton, Gary; a doctor from St. Anthony's Hospital, Michigan City; and Sister Alphonsina, St. Mary's Mercy Hospital, Gary; Sister Fulgentia, St. Margaret's Hospital, Hammond; a sister from St. Edward's Hospital, New Albany, and St. Francis' Hospital, Peru. The meeting closed with an address by the Rt. Rev. Bishop J. F. Noll.

The executive board is composed of Sister Scholastica, Wabash Employees' Hospital, Peru; Sister Margaret, St. Mary's Hospital, Evansville; Sister Leonissa, St. Elizabeth's Hospital, La Fayette.

PROGRESS AND OBJECTIVES OF HOSPITAL AND ALLIED ORGANIZATIONS

AMERICAN HOSPITAL ASSOCIATION

By William H. Walsh, M.D., Executive Secretary,
Chicago

AS THE Philadelphia convention in 1916 marked the beginning of a new era in the history of the American Hospital Association, so it may be said that at Louisville, Ky., certain progressive steps were taken and policies were adopted that will mark the year 1925 as one of transcendent importance in the affairs of the hospital world.

Standards for Membership

For twenty-five years the policy of the American Hospital Association has been to admit to membership workers in the hospital field whose vocations indicated eligibility, without very much inquiry as to their standing. So, too, when institutional membership was inaugurated the association acted on the principle that the weak hospital needed our aid as much as, if not more than the strong, and so many hospitals were accepted even though it was known that they did not meet the high standards necessary for efficient performance. It is with a sense of pride that we are able to record the fact that the great majority of the hospitals originally omitted which were not then able to meet the exacting requirements recognized as desirable, have since entered the class of the best hospitals on the continent. The realization of our hopes conclusively proves that the policy then adopted was wise.

But standards that were difficult to attain in years past have now become so universally adopted by the hospitals of America, and the public has become so familiar with modern hospital practices that the institution that does not meet the requirements of the day is the exception in any community. Even the patient is inclined to ask embarrassing questions of the hospital that does not provide the same efficient service that has been elsewhere received.

In the belief that the association had reached a stage in its existence when more careful inquiry should be made of all applicants, there was adopted at Louisville a set of principles of hospital administration for use in gauging future applicants. Thus the association will be assured that henceforth hospitals becoming members will have accepted those principles of hospital administration that have been approved by the American Hospital Association.

In approving of the purchase of a new and spacious home for the association the members have taken another step in trying to establish a national centre for hospital activities.

We hope and expect to house in our new building other organizations interested in affairs concerning and allied to hospital interests, such as social service, welfare, occupational therapy, physiotherapy, dietetics and nursing education. A large room ideally located, with adequate daylight and wall space for stacks, is to be set aside for library purposes, wherein will be available to all material upon every phase of hospital work. Thus, under one roof, a visitor interested in hospital development will be enabled to study the material relating to any subject desired, gathered from all available sources, while being offered the opportunity of personally consulting with the technical experts and specialists constituting the staffs of the various allied organizations.

Personnel Bureau

In the new building will also be located the bureau for hospital personnel, a new activity announced at the recent convention. "The aim of the bureau is to assist hospitals to secure qualified and satisfied personnel and thus increase efficiency by reducing turnover. To this end careful investigations are to be made in all cases and both institutions and applicants are expected to give at least one month's notice of intention to change. The bureau will reserve the right to decline service to anyone failing to meet its requirements." (Extract from statement of policy of board of trustees, American Hospital Association).

The bureau is conducted as a separate and distinct activity of the American Hospital Association under the personal direction of the executive secretary, whose advice and counsel in the selection of candidates and in placing qualified hospital workers in suitable positions is available to all applicants. In the pursuit of this activity the closest possible relations are maintained with all other organizations.

For a long time the trustees as well as many other leaders in the association have recognized the fact that committees have been much hampered by the lack of technical assistance in the conduct of their research. It is not an exaggeration to say that the greatest accomplishments that may be credited to the American Hospital Association have come from the unselfish and untiring labors of a small minority of the membership serving on committees. The time has come

when the association must furnish to these committees that technical assistance without which valuable time is wasted and the correlation of needed information delayed. We shall always seek the counsel and directive force of our committees, but when they are able to lean more upon the machinery of the association and devote their time to formulating plans and outlining principles, then will their true potentialities be realized.

Research Bureau to Be Organized

It is therefore hoped that very shortly after we secure adequate working quarters there will be established a research bureau, presided over by a director qualified to act as the secretary of all technical committees and to carry out the many lines of research that have already been started, and others that have not yet been commenced. It need not here be pointed out that if a research bureau had been in existence, rendering the assistance that committees have the right to expect, some of the meritorious committee reports submitted during the last few years would have been greatly enhanced in value.

The intensive study of the simplification of supplies, standardization of biological stains, investigation of soaps, cleaners, and polishing compounds, testing of flooring materials, cost finding and accounting, surveys of hospitals and communities, analysis of liability insurance rates and practices, and many other lines of endeavor of interest to hospitals are awaiting assistance from the association that can be forthcoming only when a bureau charged with the function of technical research has been made available to our committees.

The following are some of the functions within the scope of the research bureau:

- (a) To establish liaisons with all technical committees.
- (b) To carry on research along lines indicated by our committees and trustees.
- (c) To conduct independent investigations of various phases of hospital activities for the consideration and study of committees yet to be appointed.
- (d) To conduct such hospital surveys as may be requested, with the object of aiding those institutions to meet modern requirements and to indicate the direction of future development.
- (e) To conduct community studies of hospital service to the end that this branch of public welfare may be coordinated with all others, and that such communities may have some assurance that their hospitalization program conforms to generally accepted standards and accepted economic principles.
- (f) To maintain continuous contact with all other technical bodies working along lines touching hospital activities, so that there shall be no unnecessary duplication of effort.

By the unanimous vote of the association, after endorsement by the resolutions committee, the recommendation of the legislative committee that a legislative reference bureau be established, was adopted. The next step, which will be taken as soon as possible after occupancy of the new building, will be the appointment of a director versed in legal affairs in relation to hospitals.

Legislative Reference Bureau

It would seem to be an obligation of the American Hospital Association to come to the aid of its membership when inimical legislation threatens. We are suffering today from a plethora of useless, inexpedient and harmful legislation which is gradually but surely encroaching upon and endangering the foundations upon which our eleemosynary institutions have been successfully developed and supported. The great system of purely voluntarily supported hospitals is one of the outstanding achievements of our democracy, into which has gone a large part of the moral energy which three generations of men and women have been able to spare from the necessary task of earning a living. Into these hospitals have entered, and are constantly entering, many of the vast fortunes accumulated in this land of limitless opportunity. In them are extended today the finest efforts of the best citizens of the land, and the American Hospital Association is the only national organization to which these people and their institutions can appeal for support when their time-honored rights are threatened by those who would ruthlessly break down the high ideals and practices that have cost so much to attain.

Hospitals today are assaulted by the cults in their desperate efforts to gain public support for their "half-baked" theories by the use of the cloak of respectability which they consider only achievable by hospital affiliation. Various misguided adherents of anti-vivisection, anti-vaccination, and pseudo-scientists are exerting their political strength even to prevent the establishment of needed hospitals.

Unfortunately some physicians who resent the application of necessary rules and regulations that affect their incomes are resorting to legal action in efforts to overrule the governing bodies of such institutions.

These and many other reasons impelled the association by unanimous vote to adopt the recommendation of the legislative committee that a legislative reference bureau be established.

The director of the legislative bureau will establish working relations with committees in each state and province, and also with other sources

from which legislative and judicial information may be obtained. In so far as is possible, he will work through local groups acting as their consulting counsel, and furnishing to them such information, data and decisions as may be helpful. It will not be the function of this bureau to initiate legislation nor to intercede in local affairs unless specifically requested to do so. Local groups requiring the presence of the director of the bureau will be expected to pay a reasonable fee for the service, but all services rendered from the central office will be free of charge to all hospitals.

"Donors" and "Benefactors"

Until the Louisville convention no provision existed in the constitution and by-laws of the association for contributions toward an endowment fund. This has been remedied by the adoption of the following amendment:

"Contributors to the permanent fund of the American Hospital Association of sums of not less than \$100 shall be known as "Donors." Contributors to the permanent fund of \$500 or more shall be known as "Benefactors."

Donors and Benefactors, though not entitled to vote as such, shall be welcome at all meetings of the association and their names shall be perpetually recorded and published in the Annual Proceedings—and they shall receive a copy thereof.

If eligible for membership they may become Life Members upon application to the Membership Committee.

From this source there will gradually accumulate an endowment fund, the interest from which will be used for the conduct of special studies in the hospital field.

The Aims of the Association

The American Hospital Association is rapidly reaching a stage in its history when it may more adequately meet the obligations assumed when its constitution was adopted. These may be interpreted to be: To promote the health and welfare of the public so far as this may be accomplished by the conduct and elaboration of effective activities that will aid hospitals to maintain the most advanced methods in the planning, equipment, organization and management of hospitals, dispensaries and kindred institutions; to aid all such institutions in the practice of economy and efficiency in administrative and professional procedures; to use its influence in fostering legislation that is salutary and opposing that which is inimical to the public, and, finally, to strive for harmonious cooperation with all other organizations whose aims and objects are coordinate with those of this association.

When the association is able to do all the things

that must be done in order to accomplish these aims it will be able to fulfill the expectations of its most optimistic well-wishers.

No more suitable conclusion can be made to these remarks than to quote from the report of the board of trustees read at Louisville: "The association has reached its period of maturity, but is still youthful. It is rapidly growing in strength and wisdom. It has a great future of usefulness before it. If its members continue to be as appreciative of its worth and as confident of its success as they have been in the past, we need not fear to initiate the broad and constructive undertakings confronting us, always being guided by the wish to promote the usefulness of hospitals, in our own chosen field in particular, and to the world in general."

CATHOLIC HOSPITAL ASSOCIATION OF THE UNITED STATES AND CANADA

By Edward F. Garesché, S. J., Editor, *Hospital Progress*

Milwaukee, Wis.

DURING the year 1925, the Catholic Hospital Association celebrated two notable anniversaries. The first of these was the tenth anniversary of its establishment at the first convention held in Milwaukee, Wis., in 1915. On that occasion, at the summons of Charles B. Moulmier, S. J., a devoted group of hospital Sisters met together and established the association which has grown so prosperously and whose activities have been so beneficial.

Five years later, in 1920, there was launched the official organ of the Catholic Hospital organization, *Hospital Progress*, and this past year thus brought the fifth anniversary of the establishment of the magazine for Catholic hospitals.

There are in the United States and Canada some 750 Catholic hospitals, almost all of them under the care of the nursing Sisterhoods. Of these 515 are members of the Catholic Hospital Association. Besides the general conferences, which are held every year and which many Sisters attend, there are a number of regional conferences that have annual meetings in various parts of the country. At these meetings questions of great interest and utility to the hospital personnel are discussed.

Rapid Growth of Catholic Hospitals

The growth of the Catholic hospitals has been very rapid and is continuing with increased vigor. At the present time many Catholic hospitals have either just completed or are now planning and erecting additions to their hospitals, while the

existing facilities for the care of patients are often greatly taxed.

Keeping pace with this material development, the standards of the members of the Catholic Hospital Association are being raised and the statement was made by Dr. Franklin H. Martin, director general of the American College of Surgeons, speaking at a banquet of the Catholic Hospital Association, that no group of hospitals in the United States and Canada has shown a greater spirit of cooperation or has advanced more rapidly along the lines of the program of standardization proposed by the American College of Surgeons than has the Catholic group.

Hand in hand with the development of their work, the Catholic Sisterhoods are endeavoring to train their members to meet the new requirements of hospital administration and practice. To help the Sisters in this work and to provide for hospital workers in general the best facilities in hospital education, the Catholic Hospital Association has recently established, in affiliation with Marquette University, Milwaukee, Wis., a college of hospital administration, a normal school for hospital teachers and school for technicians. At the recent meeting of the American Hospital Association, the program of the college of hospital administration was approved as a model curriculum and the college was recommended to hospital workers everywhere.

The growth of the committee of the association and the careful study which each of these committees makes of its department of hospital work, deserves special mention. The work of these committees has in many cases been thorough and interesting and the contribution which they are making to hospital knowledge is noteworthy.

First Convention of Nursing Guild

This year was held the first annual convention of the International Catholic Guild of Nurses, established by the Catholic Hospital Association. This guild is a department of the association and has as its purpose to group together the graduates of the Catholic training schools and those who are in sympathy with Catholic ideas so as to encourage them and give them special educational opportunities. Members of the guild also become members of the Catholic Hospital Association and partake in its privileges. They receive *Hospital Progress*, and also special bulletins which are sent out from time to time and it is purposed to secure a full-time executive secretary—a highly qualified graduate nurse—to conduct a bureau of information of nursing opportunities for the benefit of the nurses.

The guild also proposes to promote the estab-

lishment of scholarships for its members and to organize lecture courses and other special activities for nurses. It seeks to encourage its members to take an active part in the work of the general associations and does not wish to form an exclusive or competitive society. It has grown rapidly and now has members in 200 cities of the United States, ten cities in Canada and two in Europe. Non-Catholic as well as Catholic nurses are welcome to affiliate themselves with this guild.

Hospital Progress, the official organ of the Catholic Hospital Association, is growing apace and seeks to give a faithful picture of the hospital world in its progress and ideals and to serve as an expression of the constantly increasing activities of the association. The hospitals of the United States and Canada owe a duty of inspiration and example to the entire world and the name of the magazine indicates its ambition and desire to chronicle and point the way to the progressive achievement of their ideals. Without interfering with the interests of other and older publications in the field, the magazine has grown constantly and looks forward to still greater service to the hospitals in the future.

A recent contribution to hospital literature entitled *The Patient's Book* has proved very successful in supporting the morale of the patient and keeping him in sympathy with the hospital. A special edition of this book is now being prepared for non-Catholic hospitals, in which everything is revised to suit the particular requirements of non-Catholic institutions.

Other publications for the special service of the hospitals are also under way, and it is hoped that the association may be able through its press to render very substantial service, not only to Catholic hospitals, but to all hospitals that prize the ideals of unselfish service and wish to realize the spiritual and ethical possibility of hospital work.

Another feature of the work of the association that deserves notice is its activity in behalf of the medical field. It is well known that medical missions are a powerful help to Christianizing pagan lands and the medical mission department of the Catholic Hospital Association is made up of a group of doctors and nurses who hold special meetings to discuss the needs of the mission hospitals and dispensaries in China, India, Japan, Korea, Chaldea and other mission fields.

All in all the year of 1925 has brought many good things to the Catholic Hospital Association. It has been able to cooperate with other associations, to develop its own plans, without interfering with those of others and to lay the foundations of still greater work in the future.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION

By Newton E. Davis, D.D., President,
Chicago

THE American Protestant Hospital Association has the following objectives:

1. A plan whereby the hospitals affiliated with Protestant or Evangelistic Churches may be coordinated for the purpose of material improvement and cooperation in promoting hospital efficiency. This type of hospital represents the spiritual, social and healing agencies of Christianity. The work of the hospital is vitally related to the everyday life of the community.

2. The association seeks to secure the adoption and maintenance of the highest type of nurse training schools, to enlist the best type of young womanhood as nurses in these schools, and to inform and educate the public in the use of these institutions.

3. To place a high grade of service within the reach of neglected and needy people, to promote all types of community service that affect public health and to aid all hospitals in reaching the highest standard of service relating to medical, surgical and nursing service.

The association has made marked progress during the past five years in advancing the above ideals. The membership of the association represents institutions in all sections of America. The annual meetings have proved of great value. The spirit of fellowship and good will resulting from inter-church relationships as promoted by this association has been of great value. The future program of the association is bright with promise.

AMERICAN COLLEGE OF SURGEONS

THE year 1925 marked a notable expansion of the standardization work of the American College of Surgeons. In addition to making its eighth survey of hospitals of 100 or more beds, its fourth survey of hospitals of fifty to 100 beds; the second survey of hospitals of from thirty-five to fifty beds and the national homes for disabled volunteer soldiers, the college extended its work to include U. S. Army, U. S. Navy, U. S. Public Health Service and U. S. Veterans' hospitals.

During the year a total of 2,380 hospitals were surveyed, 1,365 of which met the minimum standard in every respect, while 199 were conditionally approved. Thus 1,564 hospitals or 65.7 per cent of those surveyed were approved.

In addition a number of hospitals in foreign countries were visited and nine of them appear on the approved list. They are The Royal Alexandra Hospital for Children, Sydney, New South Wales,

Australia; Ancon Hospital, Ancon, Canal Zone; Hunan-Yale Hospital, Changsha, China; American Hospital, Paris, France (conditional); Queen's Hospital, Honolulu, Hawaii; Presbyterian Hospital, San Juan, Porto Rico; Dunedin Hospital, Dunedin, New Zealand; Gynecological Hospital, and Maternity Hospital, Montevideo, Uruguay.

That there is an increasing interest on the part of foreign hospitals to have their hospitals on the approved list and surveyed by the college is shown by the recent invitation of the hospitals of New Zealand and Australia to Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, hospital activities, to make an extended study of the hospital systems of those countries for the purpose of making suggestions and recommendations for improvements. Dr. MacEachern is now in New Zealand making this survey.

A glance at the statistics of the 1925 survey shows a gradual increase in the number of hospitals meeting the minimum standard and an encouraging response on the part of hospitals not yet meeting the requirements to bring their standards up to those of the approved list. In this connection it is significant to note that during the past year the college directed its efforts particularly towards hospitals not on the approved list and those that have appeared on former lists as conditionally approved.

The survey for 1926 will be carried on similar to that of former years excepting that insofar as possible there will be a districting of the United States and Canada and the organization of a permanent staff of hospital visitors so that the college will be able to keep a more continuous contact with each hospital throughout the year.

Present plans point to a more intensive study of the hospital in its various physical phases and greater attention directed to the spirit of the institution in its relation to the principles of standardization and care of the patient.

Representatives of the college are also planning on being present at as many staff conferences as possible with a view to assisting institutions in carrying on this feature of the minimum standard as it is intended.

This step will be taken in view of the fact of the difficulties experienced in many hospitals in establishing and carrying on regular staff meetings that are essential to the progress of medical science and hospital efficiency.

The great demand by hospitals of every country for personal services from the college will, as far as possible, be met by the Hospital Information Service Department which will be prepared to give attention to individual hospitals in solving their problems attendant upon standardization.

COUNCIL ON MEDICAL EDUCATION
AND HOSPITALS OF THE A. M. A.

THE Council on Medical Education and Hospitals, which is charged with the duty of representing the American Medical Association in all matters relating to medical colleges and hospitals, finds that about 30,000 physicians are on the staffs of hospitals in the United States and probably an additional 50,000 physicians are regular patrons of hospitals.

One of the council's chief services in the hospital field has been the accrediting of hospitals for the training of interns. That work was begun eleven years ago and has been kept up with constantly increasing thoroughness by adding to the approved list those hospitals that on investigation and inspection have been found to provide acceptable internships, and by removing from the list those that have failed reasonably to meet the steadily increasing requirements or that no longer desire to employ interns. The list of approved hospitals was completely revised twice during 1925 and the last revision has just come from the press and is available at the office of the council, at 535 North Dearborn Street, Chicago.

Many hospitals that admit only special types of patients are not in position to furnish general internships, but, nevertheless, are splendid places for medical graduates to prepare for specialization after they have served in a general hospital. A list of such hospitals has been prepared and this is likewise undergoing constant revision. As hospitals are developed to meet the requirements, they will be added to the list to be published.

A vast amount of data was published in the hospital number of the *Journal of the American Medical Association*, March 28, 1925. Among its special features that issue included a report regarding the use of the hospital by physicians not on the staffs—in other words a survey of open and closed hospitals. A survey of clinical laboratories also is just being completed.

Another thorough census of all hospital facilities in the United States is now nearing completion. The report of that census will appear in an early number of the *Journal of the American Medical Association* and will give, among other data, the name and location of every hospital of this country, its bed capacity and average number of patients. The hospital facilities for each state, county, and town in the United States will also be shown.

Every line of work undertaken by the council is demanding increased attention, in line with the clearer appreciation of the hospital's importance.

SUPERINTENDENTS OF THE NORTHWEST
CONFER

Hospital administration problems, particularly those that beset the small town hospital, were threshed out at the meeting of the Northwest Hospital Association at Seattle, Wash., in November, when about fifty superintendents of hospitals in Washington, Oregon and Idaho gathered for round table discussions and addresses on pertinent points of hospital management.

Dr. Malcolm T. MacEachern, formerly superintendent of the Vancouver General Hospital, Vancouver, B. C., and now associate director of the American College of Surgeons, who passed through Seattle at the time of the conference, gave a talk on the standardization movement before sailing on a four months' survey of hospital conditions in Australia and New Zealand.

Through standardization and complete diagnostic tests, Dr. MacEachern believes that much unnecessary surgery may be eliminated, and that patients may be restored to health and be able to leave the hospital more speedily than hitherto. He stated that the time of the average patient in the hospital can be shortened two days, through efficient, standardized methods.

State Rates for Patients Discussed

State rates for patients who are in the hospital as beneficiaries of the state industrial compensation act were discussed by F. McLean, superintendent, Hoquiam General Hospital, Hoquiam, Wash., who developed the fact that "the hospital has no redress if the state, on the recommendation of its medical adviser, cuts the amount of the hospital bill in an industrial case on the ground that the patient did not need to remain in the hospital for the length of time he was there. The hospital, however, has no jurisdiction over the discharge of the patient, as this is a matter to be decided entirely by the attending physician."

A number of women superintendents of hospitals, who are making notable success of their work in the institutions of the northwest, were present and gave interesting papers presenting various viewpoints of importance.

The question of bobbed hair for nurses came up during the course of the conference. Dr. MacEachern had no objection to this fashion, but Emily L. Loveridge, one of the leading hospital superintendents in the Northwest, and for thirty-five years superintendent of the Good Samaritan Hospital, Portland, Ore., believes that bobbed hair interferes with keeping the nurses' caps on straight.

Miss Loveridge has developed the Good Samaritan Hospital from an institution with only a score of beds to one of the largest hospitals on the Pacific Coast. She went thoroughly into the problem of the small town hospital, which, she stated, suffered from economic pressure because its overhead for laboratory equipment is similar to that of a larger institution although it has less revenue and less potential support.

Adda Knox, superintendent, St. Luke's Hospital, Bellingham, Wash., brought out an interesting point with regard to the opportunity that the newspaper of the community affords in bringing the hospital before the public.

In 1254 Saint Louis founded the Quinze-Vingts (Three Hundred) Asylum, to accommodate three hundred blind persons. He also did much for general hospitals; and a hundred years afterwards King John II founded the first orphan asylum in Paris, an example which was followed by Charles VII in 1445.

NOTES ON ADMINISTRATIVE PROCEDURES

X-RAY TECHNIQUE AND PROCEDURE*

A RADIOGRAPH is merely a shadow picture. Therefore, to avoid distortion of the image, care must be taken to place the subject symmetrically with regard to the tube.

When rays pass through material the substance is called "transparent" to radiation. If little or no radiation penetrates, the material is said to be "opaque." The terms transparent and opaque refer to the action of the material with respect to a specific type of radiation.

General Instructions and Precautions:

1. Excessive exposure to x-rays results in serious injury to the skin. Such injury may not manifest itself at once, but may develop some weeks later. To a degree the action is cumulative, so that a single dose, too small for injury, may be harmful when frequently repeated. Skin burns depend on the following:

- a. Distance from target of x-ray tube to skin during exposure.
- b. Voltage or spark gap used.
- c. Current through tube.
- d. Duration of exposure.
- e. Nature and thickness of filter used.

It should always be remembered that it is much easier to prevent an injury than to cure it.

2. X-ray apparatus is expensive and should be handled with great care.

3. Before closing the operation switch, always observe whether high tension wires are sufficiently far from the patient and assistants.

4. Make all tests of tubes, etc., on low power when possible, avoiding unnecessary speed at all times.

5. Tubes should never be tested when the patient is in position.

6. Be sure that the current is passing through the filament of a Coolidge tube before closing the main transformer switch.

7. Definite order and sequence in various details of examination will save time and prevent errors.

To avoid confusion and possible error, plates should be marked at the time of exposure.

Intensifying Screens:

The screen should be firmly fixed to the back of the cassette and should be kept scrupulously clean. Wipe off dust with a three-inch camel's hair brush, if available, or with a clean cloth, and never touch the surface with wet or greasy fingers. Insert cleaned film and make certain that the springs press the screen firmly against the film.

Care in Handling Plates and Films:

Plates and films must be kept well protected by lead when in the x-ray room. A lead lined partitioned box should be used for this purpose. Where much work is done two boxes should be provided, one for exposed and the other for unexposed plates. Plates and films not protected in this way have a tendency to become fogged or light-struck, and are thus unfitted for use.

The value of marking the patient's name and other information on the film has long been appreciated. The following method, described by Dr. Robert B. Taft of Bellevue Hospital, New York, is of interest.

About 25 per cent of standard mucilage acacia is added to the ordinary writing ink. With a heavy stub pen write the desired information on a slip of paper. Before the ink has had time to dry sprinkle with powdered lead shaking off the excess. This will leave a thick ribbon of lead enmeshed in the form of writing. The strip of paper is then placed alongside the part to be roentgenographed and the exposure made in the usual manner. Such lead writing is more efficient than block lead numbers. Use good quality nonabsorbing paper.

Guide for Dark Room Work:

Mix all solutions according to instructions and see that the chemicals are actually dissolved.

Keep all trays clean, and do not use insufficient or too old a developer.

Never handle plates or films with wet or greasy fingers either before or after exposure.

Tank Development:

The plate is placed in a special frame on a holder and hung vertically in the developing tank. With a strong developer, stirring while moving the holders will prevent vertical streaks.

Temperature of developer should be between 60° and 70° F. If hot the developer works fast and is likely to fog the plate, if cold, it is slow and unsatisfactory. To cool the solution ice water may be put into a fruit jar and the jar immersed in the developer.

As the hypo crystals will ruin the negative, the hypo must be thoroughly removed. This is done by washing in running water from thirty to sixty minutes.

*This article was written for our column, "Notes on Administrative Procedures," by J. Goodfriend, assistant general superintendent, Montefiore Hospital for Chronic Diseases, New York.

Röntgen Department—Montefiore Hospital

Patient.....Ward.....

The.....of this patient is to be X-Rayed tomorrow. The patient may have supper and on night rounds should be given 1½ ounces of castor oil. It is highly essential that no other cathartic be substituted. In the morning the patient should not be given any breakfast.

If in doubt, consult this department. Kindly send this slip together with chart, when patient is sent to the X-Ray Department.

Date.....192.....

Figure 1. Form supplied to the medical and nursing staffs for the preparation of patients requiring examination of the lumbar spine, sacrum, pelvis, genito-urinary tract and gall bladder.

If the bath appears milky it can be cleared by adding acetic acid.

A foggy plate is usually the result of using developer which is either too warm, or improperly mixed, or too long a period of development.

Records:

The importance of correctly recording all information obtained by means of x-ray cannot be overestimated. A conference between the surgeon and the roentgenologist is very desirable in order that each may have the advantage of the other's personal opinion.

Fluoroscopy:

Fluoroscopy is the method of making studies of opaque objects by means of x-rays and the fluorescent screen. One should be in the fluoroscopy room ten to fifteen minutes before beginning study to allow the eyes to become accustomed to the darkness. All light which does not originate in the ex-

cited portion of the fluorescent material should be excluded. The following conditions should be observed to insure the best results.

1. Control in both voltage and current in tube wherever possible.

2. A fine focus tube.

3. As small a diaphragm as possible.

4. A good screen.

5. Eyes sensitive to screen light by preparation in the dark room for a sufficient period to insure good vision.

6. Those accus-

tomed to using eyeglasses should not remove them when doing fluoroscopic work.

Dental X-ray:

The following points should be observed in dental work.

1. All sharp corners of the wax paper covering must be folded over and softened.

2. The films will become pliable and take the

Röntgen Department—Montefiore Hospital

Patient.....Ward.....

The gastro-intestinal tract of this patient is to be examined. After noon of this day, kindly give no medication of any kind. Patient may have supper. In the morning give no food, test meal, lavage, etc., which will affect the gastro-intestinal tract, until further notice.

If in doubt, consult this department. Kindly send this slip together with chart when patient is sent to x-ray department.

Date.....192.....

Figure 2. Form covering the preparation of patients requiring examination of the gastro-intestinal tract.

curve of the plates more readily by bending them over the end of the finger and thumb.

3. Patient should breathe deeply through the mouth while placing film to prevent gagging.

4. In very troublesome cases spray the palate and pharynx with camphor water.

5. Be sure film is far enough in mouth to include root structure.

6. Observe position of film after patient's thumb or forefinger is in place to hold it.

7. The patient should hold his breath during the actual exposure.

8. The x-ray tube must be adjusted to the proper angle in every case.

Cooperation of the x-ray department and the medical and nursing staffs is most important. Inadequate preparation of the patient will often make successful x-ray plates an impossibility. The x-ray department depends entirely on the ward physician or nurse to see that the necessary and important instructions are carried out.

A convenient method of instruction in the preparation of a patient is by means of printed slips to be supplied by the x-ray department. With such a slip the patient's name is merely filled in the space provided. As an example, for the examination of the lumbar spine, sacrum, pelvis, genito-urinary tract, and gall bladder, the form shown in figure 1 may be used. For the examination of the gastro-intestinal tract, the form in figure 2 may be used. After the six-hour examination has been made, the form shown in figure 3 may be sent to the ward with the patient.

For Kerasol test the following form is used.

Gall Bladder Visualization

Kerasol Test

Nurse in Charge—Ward..... Date.....

Patient's Name.....

1. Is *not* to have a cathartic.
2. Eats usual breakfast and lunch. Light dinner at 6 p. m. Eliminate fatty foods. No further food until notified by x-ray department.
3. Starting at 9 p. m. give two capsules every fifteen minutes until all are taken. Do not break

Roentgen Department—Montefiore Hospital

Patient.....

Ward.....

This patient may now have food. Kindly do not give any medication, test meal, lavage, enema or anything else which will affect the gastro-intestinal tract, until further notice from this Department.

If in doubt consult this Department.

Date.....

192

Figure 3. Form that accompanies the patients when he returns to the ward after the six-hour examination has been made.

capsules. Drink 10 to 12 glasses of water during this time.

4. Lie on right side during this period and for an hour or more afterwards drink cold water every half hour until bed time.

5. An enema to be given at 7 a. m. the following morning.

6. Report at x-ray department at 9 a. m. and 1 p. m.

7. Patient may eat after 16 hr. p. c. plate is taken (1 p. m.)

WHAT THE SURGICAL DRESSING CART SHOULD CONTAIN

Where dressing carts are employed the following list of items, compiled by Maud McClaskey and Helen Clark, of the Farrand Training School for Nurses, Harper Hospital, Detroit, will be found an excellent guide to contents:

Instruments:

- 2 hemostats
- 2 pairs scissors
- 2 probes
- 2 dressing forceps
- Sterilized and placed in sterile covered instrument tray
- 1 pair bandage scissors
- 1 long forceps (sterilized) in jar containing 2 per cent lysol solution.
- 1 sterile glass bulb syringe wrapped in towel
- 1 skin clip remover kept in 2 per cent lysol solution
- Sterile dressings, basins and gloves
- Drum containing large pads
- small pads
- gauze squares

Cotton rolls
Gauze rolls
Towels

Solutions:

Hydrogen peroxide
Tincture of Iodin
Alcohol 95 per cent
Silver nitrate 25 per cent
Mercurochrome
Boric acid saturated solution

Iodoform gauze
2 dressing basins
Rubber gloves

Benzin
Ether
Liquid soap
Normal saline
Dakin's solution
Carbolic

Ointments:	
Sterile vaseline	Scarlet red ointment
Unguentin	Lubricant
Zinc oxide ointment	
Dusting powders:	
Boric acid powder	Aristol
Glove	Stearate of zinc
Iodoform	
Miscellaneous:	
Sterile applicators	Oiled muslin
Sterile tongue depressors	Tape measure
Adhesive straps	Collodion
Adhesive plaster	Dressing papers
Bandages 2-inch, 3-inch, 4-inch	
Equipment for Rehfuß set:	
Hemostat	Rubber apron
Four sterile test tubes	Mouth gag
Drainage bottle	Duodenal tube
Three ozs. magnesium sulphate	20 c.c. Luer syringe
Equipment for Blood transfusion:	
Small rubber protector	
Sterile towels	
Sterile squares	
Iodin	
Alcohol	
Tourniquet	
Sterile needles—15-18-19 gauge 1½ inches	
Sterile Kelly bottle and rubber cork with 2 holes	
Rubber tubing and bulb	
Flask normal saline	
Sodium citrate 2.5 grams for 500 c.c. blood	
Two sodium bandages	
Dressing papers	
Equipment for spinal puncture box:	
Sterile syringe for local anesthetic kept in sterile enameled jar	
Two sterile spinal puncture needles in tubes	
Three sterile test tubes	
Sterile towels	
Sterile gauze squares	
Sterile cotton	
Alcohol	
Iodin	
Collodion	
Dressing papers	
Equipment for Blood Chemistry:	
Sterile gauze squares	
Alcohol	
Tourniquet	
Sterile needles gauge 20 inches tube	
Four sterile test tubes	
Container for used needles	
Dressing papers	
Laboratory cards	
Equipment for intravenous:	
Rubber protector	
Sterile towels	
Sterile squares	
Iodin	
Alcohol	
Tourniquet	
Sterile needles gauge 15-18	
Sterile graduate with tubing	
20 c.c. Luer syringe	
500 c.c. graduate	
Hemostat for clamping tubing	
Two-inch bandage	
Dressing papers	

FIRE FIGHTING APPARATUS

At one southern hospital, all chemical fire extinguishers and hose nozzles are polished every day. This procedure serves as a medium through which the idea of cleanliness is constantly impressed upon the personnel, and helps to keep the equipment in order. All hose and hose carts are tested once a week, and all chemical containers are refilled every six months.

Because this hospital is somewhat remote from an established fire department, the superintendent has an agreement with a commercial organization whereby he might be immediately supplied with an adequate number of large tents, in the event of a fire.

CONCERNING LABORATORY PERSONNEL

The clinical laboratory is one of the important service departments or units in the entire organization of the hospital. It is one of the contributing units in service to the patient and comes under the medical division, taking its place both in the diagnostic and therapeutic aspects of medicine. It must be thoroughly organized and a department head or director is necessary, who shall be responsible to the hospital management for the operation of this particular department. Assistants, technical staff and others should be directly responsible to the head of the department.

The entire staff must be imbued with earnestness in their work and the doing of everything to render the best service possible to the patient. They must also be imbued with the spirit of cooperation, coordination, efficiency and economy in the management and operation of the department. Underlying the technical service there must be a distinct personal interest in the department itself as a unit of the larger or more complete organization of the hospital.—*Journal of Laboratory and Clinical Medicine.*

ROUTINE FOR LINEN DEPARTMENT

The linen department should be responsible for the care and issuance of the articles listed below. It should maintain a sufficient supply of linen, both in use and in reserve, for all normal demands, and in conjunction with the purchasing agent should make the necessary purchases for replacements.

Bed linen	Slippers
Towels	Mortuary sets
Blankets	Dish towels for private rooms
Pillows	and wards
All table linen	Nurses' uniform material
Operating room linen	Curtains
Bath robes	Orderlies' coats
Doctors' uniforms	Screen curtains

This department should exchange soiled pillows and slippers, discard or repair all worn linen and bend every effort toward waste reduction.

All requisitions for new linen or anything new pertaining to the linen department should be approved by the superintendent's office.

APPOINTING LAY COMMITTEES TO STUDY SPECIAL DEPARTMENTS

"To my mind the administrator should not appoint special lay committees to study and promote the work of special departments or services, as a mere compliment to the socially prominent women of the community, but he should consider carefully who is appointed and what their recommendations can do to help him. Some of the suggestions that those committees bring forth will probably not be practical, but many of the administrator's plans may frequently be put in the same category.

"I think that it will be found that special lay committees will stimulate not only the administration, but all lay departments of the hospital to which they are assigned to a more detailed and active study of the problems of these departments as they relate to the patient or the patient's visitor. After all, it is by the intensive study of these details that a hospital's reputation for good or poor service is finally established."—Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago.



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THE PATH AHEAD

ANOTHER year has come and with it the season of taking stock. We live rapidly nowadays and new events and discoveries tread fast upon each others heels so that we scarcely realize the distance that we have traveled since the old year was born. Yet it is a good thing to step aside at this time and look back over the road that we have traveled and determine, if possible, the direction that it shall take in the future.

There is not one of us who cannot look back and see the improvements in organization, methods, apparatus and spirit which 1925 has brought to us. There are more hospitals and better hospitals than there were a year ago; more people know the value of hospitals; more hospitals are doing better, more accurate, more sympathetic work than at the beginning of 1925. The spirit of hospitals, always imbued by the highest of human ideals, has correspondingly improved, and, best of all, when 1927 comes in and this year's work is reviewed, the same thing may be said.

One of the great joys that comes to the publishers of THE MODERN HOSPITAL is the realization that the pages of the magazine are essentially a record of human progress, of victories over disease, and of human lives made better, happier and more useful. The journal aims to talk over with the hospital field and those who serve it, these advances out of which each of us may take inspiration from his fellow-reader. May the happiness of accomplishment, the joy of labor for humanity and the blessing of many victories in the war for the salvation of man's body be yours throughout 1926 and may we all, a year from now, look back at a useful and productive twelve months.

QUEEN ALEXANDRA

THE death of Queen Alexandra on November 20, 1925, is a distinct loss to the hospital field, particularly to the nursing profession.

She was a practical philanthropist and throughout her long life was determined and unflagging in her efforts to alleviate and prevent misery and disease. She interested herself in countless hospitals and similar institutions, and her contribution to the efficiency of military nursing alone would entitle her to grateful and honored memory for all time.

When the British nation entered the South African War, little had been done by it to provide suitable nursing services for the front. Queen Alexandra who, at that time, was Princess of

Wales, stimulated the interest of a large number of civilians who volunteered their services for this important work, and it was due to her insistence that the war office sent out a substantial contingent of nurses from London to South Africa.

At the close of the South African War, Queen Alexandra's Imperial Military Nursing Service was established for the purpose of nursing the sick of the military forces in peace times and also to serve as the nucleus of an expanded organization in time of war. To accomplish this latter end a reserve service was created. Queen Alexandra's military nursing board was later formed and charged with the administration of the entire military nursing service. In 1921 Queen Alexandra's military families' nursing service was organized to look after the welfare of the wives and children of service men. Queen Alexandra's nursing services were established for the British Navy and for India, and similar organizations have been created for the air force and the territorial army.

In her connection with these organizations, Queen Alexandra was not a figurehead but took an active part in supervising the details of each of these bodies. She introduced the use of Finsen light into the London hospitals and was president of the London Hospital for the last twenty-one years of her life.

It is not surprising, in view of her direct interest and sympathetic understanding of the problems of hospitals and the profession of nursing, that her last message should have been addressed to the annual meeting of Queen Victoria's Jubilee Institute For Nurses which was held on November 18 at St. James' Palace. In it she wished prosperity to the institute, expressed the hope that its financial outlook might continue to improve and thanked all the workers for "the good cause which is so near to my heart."

TWENTY YEARS OF HOSPITAL SOCIAL WORK

RECENTLY there was held at Massachusetts General Hospital, Boston, a meeting to celebrate the twentieth anniversary of the founding of the social service department of that hospital.

This event is worthy of more than passing comment, since it marks as well the twentieth birthday of hospital social service in America. It is true, of course, that often before the year 1905 those who ministered to the needs of the sick in hospitals gave thought to the social needs of some

of their patients and tried to see that those needs were met. But so far as is known it was at Massachusetts General Hospital only a score of years ago that we have the first instance of a special worker being employed to assist in the hospital's service to the patient by helping him with respect to his social needs. This action was taken, so we are told, because a clear-thinking physician recognized the futility of treating a patient in the hospital for pathological conditions produced or aggravated by unhygienic living, and then exposing him again to those same conditions on his discharge from the hospital. Thus it was that the role of the social worker in the hospital came to be that of working with staff physicians in the diagnostic phase of their work, by investigating and evaluating social and environmental factors bearing upon the illness of patients, and on the treatment side by working with physicians and patients in an effort to overcome social and environmental obstacles to recovery and subsequent health and well-being.

Through the development of social service departments, hospitals are increasing their value to the patient by helping make more secure for him the benefits of hospital treatment. They are likewise increasing their general community value because through their social service departments there is possible a more effective linking up with many other agencies working for community betterment.

POWER IN THE RIGHT PLACE

THE ancient arrow maker was a thoroughly competent artist. With no other tool than a piece of horn or hard bone not much bigger than the handle of a tooth brush, he moulded resistant flint, obsidian and agate into arrows and spearheads and knives which were so sharp that they could be used for shaving. He did not do this by main strength or the bludgeoning blows of a heavy hammer. On the contrary, he held the piece of stone which he wished to work in the palm of his left hand. He selected the place in which he wished to flake off a piece of the stone. At this point he applied the bone or horn tool which was held in his right hand. He exerted just the right amount of pressure at exactly the right place and a properly shaped piece of stone was split off. He accomplished this because he applied the right amount of power at the right point.

The ancient maker of arrowheads was taught the basic principles of his craft by some older worker in flint, after which it was necessary for him to acquire by experience that untransferable knowledge which comes only through long

practice and through industry and intelligence. The first arrowheads that he made were probably pretty crude. Perhaps not one in fifty was true as to shape and balance. But by constant practice he reached a point where the production of masterpieces was almost automatic.

In the work of caring for the sick in mind and body, there is a multitude of jobs requiring highly skilled craftsmanship for their proper performance. The hospital administrator must know exactly how to use the power with which he is intrusted. He must be accurate in his business relations; there can be no fumbling in his leadership; he must know every job in the hospital in order that he may know that it is properly done; he must be vigilant and Argus-eyed. The superintendent of nurses must be as skillful in the solution of her problems as is the surgeon in his operating technique. The dietitian must know thoroughly the work of purchasing, issuing, preparing and serving food. The engineer must be acquainted with the family history and state of health of every piece of apparatus in the hospital. So it goes down the line to the scrub woman, who also must be an artist in her work. The superintendent must indoctrinate, stimulate and inspire this entire group to individual and collective, perfect craftsmanship, and he must weld the entire organization into an accurately functioning, highly human, sympathetic instrumentality for the care of broken humanity and the guidance of the community in the paths of health.

TALKING IT OVER

CERTAIN people in the hospital world seem to feel that it offers for them little opportunity. Some of these are under the impression that they have reached their zenith and their ambition in life seems to be merely that of holding on to what they have. Happily, this class is in the minority, and the great majority realize that this field is bounteous in opportunity.

Poets have said and pessimists have believed that opportunity knocks but once at every man's door. Nothing could be less true. Certainly in the hospital field opportunity is banging on the door with both fists every hour of the week and day. Every piece of work that we do wholeheartedly and well is welcoming opportunity in, and if we but add day by day to the little heap of accomplishments, if we try to learn how to do our work better today than we did yesterday, by and by we shall have a very considerable heap of winnings.

There is a great unknown crisis of opportunity in the lives of all of us and if we have built up and added daily to our knowledge and ability, that hour will not find us wanting. There is more room at the top than at the bottom, but we cannot breathe comfortably the rarefied atmosphere of the heights unless by daily training and exercise we have prepared ourselves for it. It is a fertile field that we are tilling. The harvest of good to our fellow man is a rich one and the personal rewards are commensurate with the energy that we expend in our up-

ward climb. For us the future is full of hope and richly overflowing with opportunity.

* * * *

THE hospital telephone operator is an important point of contact between the hospital and the outside world. All day long she is sending out electrical waves that register upon the public an impression of the efficiency of the organization. If she is courteous, if she endeavors to give accurate, snappy service, if she tries to answer the thousand and one queries that are put to her daily, she will be a continuous reflection of politeness, kindness and efficiency. On the other hand, if her work is half done, if it is careless, if it is lacking in true courtesy, if she is wanting in patience, she will create a very bad impression among those who do business with the hospital.

The operator, though, cannot properly do her work unaided. When she asks information as to the condition of a certain patient, it must be given to her promptly. All through the hospital, everyone must be on the *qui vive* to supply to her quickly and accurately the information that she requires. Having it, it is her duty to transmit it with intelligence and understanding to the inquirer. Above all, she must avoid such stereotyped phrases as "The patient is doing as well as could be expected."

* * * *

WHAT is the most important part of a needle, the point, the shaft, or the eye? The answer, of course, is that each part of a needle is equally important, that upon the integrity of a needle as a whole depends its usefulness. Similarly, what is the most important department of a hospital? There is no most important part, or all parts are most important, each of us believing, if we are interested in our work, that our portion performs the most useful and necessary labor.

However, the heart of a hospital is its department of dietetics. That department can create the greatest dissatisfaction in the shortest space of time and conversely, it can do more to help a hospital than almost any other single part of the organization. Good food well prepared, daintily and properly served adds tremendously to the patient's welfare and contributes very materially to his peace of mind. The dietitian, however, cannot make her work a success unaided. If she is scrimped on raw material, if she is given underpaid, ill-trained assistants, if she does not have proper apparatus for the cooking and serving of food, her's is an almost hopeless task. Furthermore, if she is to reach the highest degree of accomplishment, she must be kept constantly and accurately informed by those who are in touch with patients of the needs, wants and dietary idiosyncracies of the sick whom she is supposed to feed. In other words, her department is the point of a needle, the purchasing and personnel departments are the shaft, while the medical and nursing staffs are its eye.

* * *

ONE of our Pacific Coast readers raises the point that enough thought has not been given to humanizing the exterior of the hospital. He thinks that the architectural lines of many institutions contribute to the feeling of dread with which the laity contemplates hospital service. Although there has been marked improvement in recent years, he argues that even today there is an architectural austerity which is repellent. The patient has no interest in architecture—monumental, dignified or symmetrical. His interest centers around an environment that is homelike, easy, simple, informal and comfortable in appearance as well as in fact. Our reader recommends that in planning our hospitals we approach the problem with the qualities

of a home in mind, so that the exteriors will suggest the same qualities of service that do the pleasing interiors.

* * *

"WHAT shall we do with the husbands?" has been the eternal question of physicians, special nurses, hospital superintendents and other attaches of maternity hospitals. Barring the mother-in-law stories there have been more jokes told about the husband of the expectant mother than about any other one class of unfortunates. The Chicago Lying-In Hospital has taken a step toward soothing the jagged nerves of the man-of-the-house by the provision of a "Husbands' Room." Here, where births are a common-place and come under the heading of routine, something had to be done to keep the men from pacing the corridors and burning up the building with half-consumed cigarettes nervously thrown at random. The special room provided for the husbands has a terrazzo floor, several ash trays that are usually overflowing, comfortable chairs and a few appropriate cartoons on the walls. There is also a public telephone provided, but for what purpose it is not known as most proud fathers upon hearing the news are too excited to talk much less transmit a telephone number correctly.

* * *

IN THE *House News* of the Harrisburg Hospital, Harrisburg, Pa., appears this notice passed on to our readers for consideration and profit:

"The hospital is engaged in a drive somewhat different from usual hospital drives. This is a drive for savings in operation rather than for funds to carry on operations. Everybody in the hospital is enlisted in the drive.

"Every hospital attaché has in mind that he or she who turns off a radiator that is not needed saves coal in the boiler room by the shovelful. The turning off of an electric light will definitely affect the electric or power bill. The unnecessary use of the elevator uses up current that must be paid for.

"The office force is telling itself that the writing of an unnecessary letter is a waste of time, material and postage. The unnecessary use of the telephone causes a strain upon service suggesting the possible need of additional facilities with additional costs . . .

"May we ask that everybody give some thought to ways of economizing that have not yet been thought of? Contributions and suggestions will be welcomed if sent to the office of the superintendent. Don't suggest anything that will lower the hospital's standard."

* * *

JUST suppose that an ex-patient circulated the report that your hospital charged exorbitant rates because he had to pay \$7, \$6 or even \$5 a day for a private room, and the public believed him. Of course this couldn't happen in your institution because you have educated your community through proper newspaper publicity, but it is worth talking and thinking over.

* * *

AMMONIA has long been recognized as an excellent cleansing agent. Pneumonia for an equal length of time has been considered a scourge that should be cleaned up. Perhaps this accounts for the printer's substitution of "Ammonia" for "Pneumonia" in the heading on page 487 of the December issue. Or was it because pneumonia is less prevalent in hospitals than ammonia? Or did he feel he could help the work of the commission by eradicating the name as well as the disease? Or was it, as our office boy suspects, an old-fashioned printer who objected

to anything "pneu?" It is easier for a camel to go through the eye of a needle than to fathom the cerebrations of a printer. In any event we hope that the commission is able to live up to the printer's mistake and finally eradicate pneumonia even if it has to substitute ammonia.

This serious but ludicrous error will serve a good purpose, however, if it suggests not only to editors but also to hospital executives the dangers of giving orders over the telephone instead of in written form.

* * *

TALKING about pneumonia, here is an excerpt from Susan Ertz's popular novel, "Madame Claire," that has a whimsical appeal for all of us in the hospital field. Madame Claire is writing to her dear old friend who has phlebitis:

"I am so sorry you are feeling less well. How is the phlebitis? No one ought to suffer from anything with such a pretty name. Did you ever stop to think that the names of diseases and the names of flowers are very similar? For instance, I might say, 'Do come and see my garden. It is at its best now, and the double pneumonias are really wonderful. I suppose the mild winter had something to do with that. I am very proud of my trailing phlebitis, too, and the laryngitises and deep purple quinises that I put in last year are a joy to behold. The bed of asthmas and malarias that you used to admire is finer than ever this summer, and the dear little dropsies are all in bloom down by the lake, and make such a pretty showing with the blue of the anthrax border behind them.'"

* * *

IT WOULD seem that there is a growing appreciation of the value of convalescent homes. In our news section of this issue appears an item telling of the gifts to the New York Hospital for Joint Diseases, New York, of a country home on Long Island by Alfred M. Heinsheimer and to the Presbyterian Hospital, New York, of an estate at Sound Beach, Conn., by the relatives of the late J. Kennedy Tod. An excellent thought is found here for the acquisition of adequate convalescent hospitals when men of wealth can be prevailed upon to turn over their well built country properties to deserving urban hospitals.

* * *

AS THIS issue goes to press government and state legislatures have convened in most parts of the country. Out of the maze of laws that will be proposed, debated and passed will be many that either directly or indirectly affect hospital and health work. Irregular cults, osteopaths, chiropractors and other back thumpers under a hundred different names will put forth mighty effort to be admitted as regular practitioners in hospitals.

Shortsighted medical men will try by law to stop hospitals from giving physical examinations and others of the same type will frown upon out-patient service. Schools turning out quack nurses will try to lower the standards of the nursing profession; backwoods legislators will fight appropriations for health and hospital work; the anti-vivisectionists and the anti-vaccinationists will be at state capitols fighting progress; as of old, bigots will be protesting, intolerants will be condemning and a thousand others with axes to grind will be present. Unless the hospitals fight and fight hard some of these dangerous elements will either wholly or partially succeed. Every superintendent and trustee should keep well informed and see to it that his legislative representative is kept well informed during these times. Nothing will be gained by silent contempt.



The bronze doors of the new John B. Murphy Memorial, Chicago, the six large panels of which commemorate Æsculapius, the god of medicine, and five founders of modern medicine and surgery.

MURPHY MEMORIAL NEARS COMPLETION

ANOTHER step in the completion of the John B. Murphy Memorial of the American College of Surgeons was taken recently when the bronze doors on the front of the building were placed, adding practically the last complement to the exterior of the building on Erie Street, Chicago, which adjoins the main College of Surgeons' building.

The doors, shown on the preceding page, are considered by art experts to be among the finest in the country and compare favorably with the historic doors on Trinity Church, New York. They were designed and built by the Tiffany Studios, New York, the figure work in the six panels having been done by Charles Keck, a well-known sculptor of New York.

Doors a Memorial to Dr. Bridge

When it was decided to have the doors for the memorial the committee in charge of the building believed that they should take the form of a remembrance of Dr. Norman Bridge who was a close personal friend of Dr. Murphy. Following this train of thought further it was decided that some friend of both men should donate the doors and Edward L. Doheny volunteered.

On one of the panels of the doors appears the following inscription: "In Appreciation of Dr. Norman Bridge, Eminent Physician and Distinguished Philanthropist;" on the opposite panel appears: "Presented by His Friend and Companion, Admirer and Business Associate, Edward L. Doheny."

Much thought was given to the selection of subjects to adorn the six panels of the doors and the building committee finally decided the following to be the most appropriate:



One of the panels of the door of the John B. Murphy Memorial, Chicago, depicting Lister, the father of modern surgery, at work.

Æsculapius, the god of medicine,
Pasteur, a founder of science,
Osler, a great clinician;
Lister, the father of modern surgery,
McDowell, an American pathfinder in surgery,
Gorgas, a world sanitarian.

The two top panels are those of Æsculapius and Pasteur, the center two are those of McDowell and Lister, while the lower two are of Osler and Gorgas.

With the installation of two ornate bronze lamps, to be placed at each side of the doors, the outside of the memorial will be complete. While the interior is completed as far as building is concerned it has yet to be furnished and decorated. The general wall tints are cream and gold and most of the hangings and draperies will be in a rich-toned blue. An organ will also be installed.

Among the many admirers of the John B. Murphy Memorial is the eminent art critic, Sir Joseph Duveen, who ranks this building among the first two or three of its kind in the world. Many architects from all over the country have visited the building since its semi-completion and have expressed their admiration for its design. The plans were drawn by Marshall and Fox, architects, Chicago.

WHO SHOULD DETERMINE WHEN THE HOSPITAL IS SAFE AGAINST FIRE?

"Whether or not buildings that house the sick are safe should be determined by the board of fire commissioners in conjunction with the board of managers of the hospital" is the opinion expressed by Dr. Lewis A. Sexton, superintendent, Hartford Hospital, Hartford, Conn., in discussing the question of whether the fact that a hospital is unsafe so far as fire protection is concerned should be suppressed, or should the community be compelled to face the truth.

Dr. Sexton believes that it is clearly the duty of the board of managers to see that patients who seek admission are not subjected to any unnecessary fire risks, for it is not the function of the sick man to investigate the physical condition of the hospital that he enters in time of need. He comes in absolute confidence that the facilities are adequate for the treatment of his condition, otherwise he would not come.

Dr. Sexton further says that no community is worthy of a hospital that cannot and will not correct hazardous conditions of this kind if the same cannot be done by constituted authorities.

INFANT DONORS' NAMES TO BE ENGRAVED ON MEMORIAL TABLET

The Knickerbocker Hospital, New York, is particularly proud of fourteen of its alumni under three years of age who have contributed from \$10 to \$100 each toward the new hospital building fund of \$500,000. These infants are among the 370 who have been born in the hospital since 1922. The names of the young subscribers who have contributed sums through their parents will be permanently engraved on the special "Babies' Tablet" in the foyer of the new building.

The new hospital is expected to be ready for occupancy by November 1, 1926.

NEWS OF THE MONTH

IMPORTANT COMMITTEES APPOINTED AT A. H. A. TRUSTEES' MEETING

Preliminary arrangements in selecting the place of the twenty-eighth annual convention, the appointment of the nominating committee by President Bachmeyer, and other procedures of interest to members of the association featured the meeting of the trustees of the American Hospital Association at headquarters, December 15, 1925.

That the 1926 convention will probably be held in Atlantic City or in some eastern city was evident from the action taken at the meeting. The trustees authorized Dr. William H. Walsh, executive secretary, to visit Atlantic City for the purpose of determining the suitability of that city for the convention. A definite announcement of the place of meeting will be made as soon as the final decision is made.

Nominating Committee Appointed

In accordance with the action at the Louisville Convention that the president appoint a nominating committee composed of five people, one for five years, two for two years and two for one year, Dr. Bachmeyer announced the following committee for the coming year: To serve for five years, John M. Peters, superintendent, Rhode Island Hospital, Providence, R. I.; for two years, Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man.; Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, Ohio; and for one year, Carolyn E. Davis, R.N., superintendent, Minor Hospital, Seattle, Wash.; and F. O. Bates, superintendent, Roper Hospital, Charleston, S. C.

The special committee on county hospitals suggested at the Louisville convention was appointed by President Bachmeyer to begin the study of problems peculiar to county hospitals. The committee is composed of Dr. R. G. Brodrick, director, Alameda County Hospital, San Leandro, Calif.; Dr. Carl E. McCombs, Bureau of Municipal Research, New York; and Dr. C. W. Munger, medical director, Grasslands Hospital, Valhalla, N. Y.

With respect to the impending bill before Congress concerning the standardization of clinical thermometers, the board felt that it would be wise to license manufacturers agreeing to adopt standards rather than to attempt to test clinical thermometers in bulk. The legislative committee was thus requested to confer upon this matter with the proper officials in order that the bill may be so amended.

Dr. Joseph B. Howland, superintendent, Peter Bent Brigham Hospital, Boston, was appointed to succeed Dr. S. S. Goldwater, resigned, as the association's delegate to the committee working on the grading of nurse training schools.

In regard to the progress in subscriptions to the bond issue for the association's new home, announcement was made that the total subscriptions had reached \$35,900, and the form of mortgage indenture submitted by the association's attorneys was unanimously adopted. The executive secretary was instructed to send in all sub-

scriptions to the bond issue at once in order that the funds might be ready by January 1, 1926.

A memorandum of the organization of the geographical sections of the association was adopted by the trustees and the executive secretary was instructed to send a copy to each section now organized and all other hospital associations contemplating affiliation with the national body, so that these sectional associations may consider the plans outlined and offer criticisms or suggestions.

FIREPROOF HOSPITALS REQUIRED BY LOS ANGELES

Los Angeles, Calif., has taken a significant step in safeguarding the sick and hospitals of the city recently when Mayor Cryer and the city council passed an ordinance requiring that all hospitals of the city of more than one-story must occupy fireproof buildings within six months or cease operation.

This building ordinance makes it unlawful for any person, firm or corporation to conduct, operate or maintain a hospital in any buildings more than one-story high, unless such a building is fireproof in accordance with the provisions of the building ordinance of the City of Los Angeles. At the same time that the ordinance was passed last June it became unlawful to erect any building for hospital purposes one or more stories in height, unless the building was of fireproof construction. The ordinance will become effective in December, 1926.

TEN MILLION DOLLARS ASKED FOR NEUROPSYCHIATRIC VETERANS

A recommendation that \$10,000,000 be appropriated for the construction of neuropsychiatric hospitals in this country was the outcome of the recent conference of the medical council of the U. S. Veterans' Bureau, held in Washington, D. C. The recommendation was based on a recent survey of all records of Veterans' Bureau patients which show that tuberculous and general disability patients are rapidly being cured and that there is a considerable increase in nervous and mental cases.

Another decision of the council was that all medical and clinical records of each patient hospitalized should be kept under the supervision of the bureau to form the nucleus of the data to be studied and analyzed by the newly established medical department of investigation and research.

TWO NEW YORK HOSPITALS GIVEN CONVALESCENT HOMES

Two recent donations of convalescent homes to hospitals of New York indicate that the need for this type of institution is being felt more and more by individuals and the public.

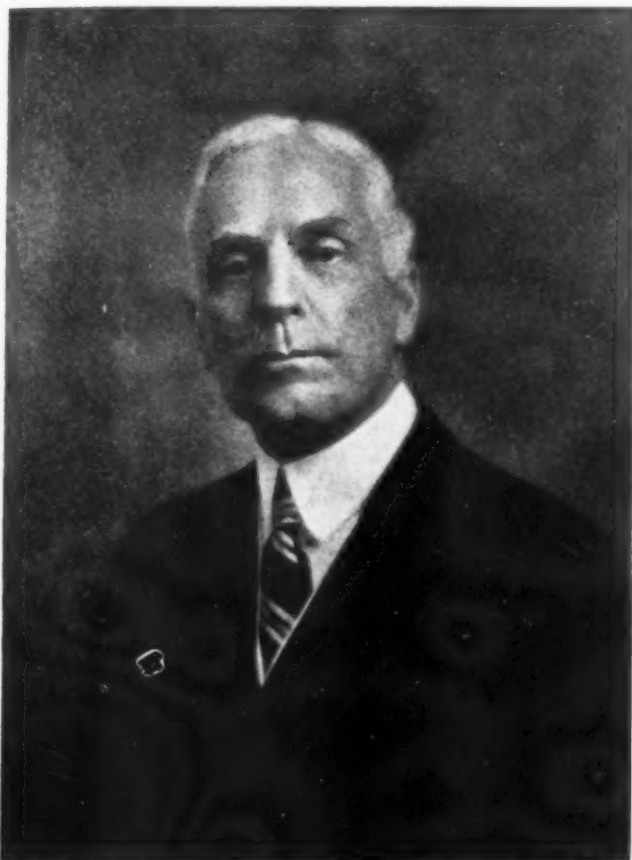
A few weeks ago the Hospital for Joint Diseases, New York, announced the donation of a \$1,250,000 convalescent home at Far Rockaway, Long Island, by Alfred M. Heinsheimer, brother-in-law of Dr. Henry W. Frauenthal,

founder of the hospital. The twenty-room home, a waterfront property of fourteen acres, will be used by the hospital as a convalescent home for crippled children.

The other convalescent home is a donation to the Presbyterian Hospital, New York, by the family and friends of the late J. Kennedy Tod. The gift includes the 117-acre peninsula and two small islands situated at Sound Beach, Conn., about thirty-five miles from the Medical Center.

TWENTY YEARS PRESIDENT OF BOARD OF TRUSTEES

About twenty years ago, friends of Saint Luke's Hospital, Cleveland, wisely secured the interest of F. F.



F. F. Prentiss who has been a member of the board of trustees of St. Luke's Hospital, Cleveland, for twenty years.

Prentiss in the institution, and induced him to accept the presidency of the board of trustees. He was at that time the president of the Chamber of Commerce of Cleveland, and felt that he was giving as much of his time and energy to civic enterprises as he could well afford. His friends assured him, however, that if he would accept the presidency of the board, they would find a successor for him at the end of a year. It seems they immediately forgot their promise and it has never occurred to them since.

During all these years he has directed the interests of the institution in a most efficient manner and has given most generously of his time and energy. He has seen it grow from a small beginning and with few friends to its present commanding position. His own personal contributions amount to several hundred thousand dollars. He has interested a large number of people in the institution, many of whom have made substantial contribu-

tions to it. Notable among the gifts is that of two million dollars from Mrs. Prentiss.

The foundations are now being laid for the new hospital, the first units of which will cost approximately two million dollars. The new institution will ultimately have 500 beds.

Mr. Prentiss has been actively associated with many of the most important movements for social betterment in the city of Cleveland, during a quarter of a century and, notwithstanding the claims that other institutions and organizations have made upon his time and energy, he has been very devoted to Saint Luke's Hospital. His intimate knowledge of its organization and the details of operation have made him a most capable and inspiring presiding officer, and the community is pleased to acknowledge his leadership.

HEALTH PROBLEMS DISCUSSED BY CHICAGO REGIONAL PLANNERS

Among the many subjects considered at the third annual meeting of the Chicago Regional Planning Association, December 2 and 3, 1925, was that of public health as related to the many communities situated in the territory being studied by this body. It was emphasized that the health problems presented are unique because portions of the three states of Indiana, Illinois and Wisconsin are concerned in the ultimate plan which it is hoped to perfect for the development of the territory within fifty miles of the Chicago loop district.

Methods of coordinating health work in this territory were discussed. Senior Surgeon C. C. Pierce, U. S. Public Health Service, in charge of the Chicago district, who is directing the health work of the commission, pointed out the immediate important problems to be considered: (1) the securing of a pure milk supply for the district; (2) the extension of goiter prevention work by the addition of iodine to foods; (3) a universal vaccination against smallpox; (4) the extension of periodic health examinations among the population.

Dr. Isaac D. Rawlings, state health officer of Illinois, in discussing the relationship of rural and urban health work stated that a uniform plan of action was needed, since diseases know no political or geographical boundaries. He pointed out the fact that there were over 2,000 official health organizations in Illinois alone, with similar conditions prevailing in Indiana and Wisconsin. His plea for the county as the health unit rather than the township as now prevails in rural communities, was ably endorsed by Dr. C. A. Harper, state health officer of Wisconsin.

The improvement of the milk supply of the region will be materially helped if the efforts of the Chicago Health Department are successful in requiring that only milk from tuberculin tested cows be permitted to be sold in the city, stated Chicago Health Commissioner Herman N. Bundesen.

The question of pollution and purification of Lake Michigan water was discussed by Langdon Pearse and A. E. Gorman of Chicago. C. B. Burdick, also of Chicago, discussed the proposed method of supplying water to suburban areas north and west of Chicago through a private corporation which would take water from Lake Michigan and, after purification, deliver it into the distributing systems of the surrounding towns.

Henry P. Chandler, a director of the association, discussed the legal powers of health officers in which he traced the development of health legislation through federal, state and municipal departments, in each case emphasizing the value of educational activities of such de-

partments over the law enforcement and police powers with which the state and municipal departments were often clothed.

ST. LUKE'S HOLDS OPEN HOUSE FOR DONORS

An open house for all donors to the hospital was held during the week of November 30—December 5 by St. Luke's Hospital, Chicago, at which time members of the women's board acted as hostesses and members of the hospital personnel guided parties through the entire new Indiana Avenue wing, which was recently occupied. The layout of the institution, the new equipment and its uses, the facilities for clinics and the out-patient and social service departments were explained and demonstrated to the visiting donors.

From the time that the visitors were received in the lobby of the old wing until they had been shown through the entire hospital, the ease and efficiency of operation was apparent. It was demonstrated that the added burdens on the service facilities have been assumed without undue friction.

Chief among the features of open-house week were the announcement that an electric sign, featuring the hospital's name, is to be placed on the roof of the new wing, and the demonstration of a new radio-stethoscope, which, through the use of head phones, amplifies the heart beat, pulse and respiration of a patient and simultaneously photographs them on a long strip of negative. This machine also demonstrated its ability to tune out certain sounds of the heart so that others can be heard and recognized more easily.

UNIVERSITY AND LINCOLN HOSPITALS BENEFICIARIES OF DUKE GIFTS

A six million dollar endowment for the medical school and hospital of Duke University, \$25,000 for a new home for the colored nurses of the Lincoln Hospital, Durham, and an additional \$5,000 for the liquidation of the debts of that hospital are among the definite contributions of the late James B. Duke, and B. N. Duke to the hospitals of the Carolinas.

As was previously announced in our September issue, through the will of the late James B. Duke, 32 per cent of the income of the Foundation or a sum ranging from \$500,000 to \$600,000 annually will be available for assisting hospitals. Under the terms of the gift funds will be available in the proportion of one dollar a day for each free bed in hospitals not operated for profit.

The will, probated October 24, provides \$10,000,000 for a medical school, \$4,000,000 to be used for the plant and \$6,000,000 for endowment of the medical school and hospital of Duke University.

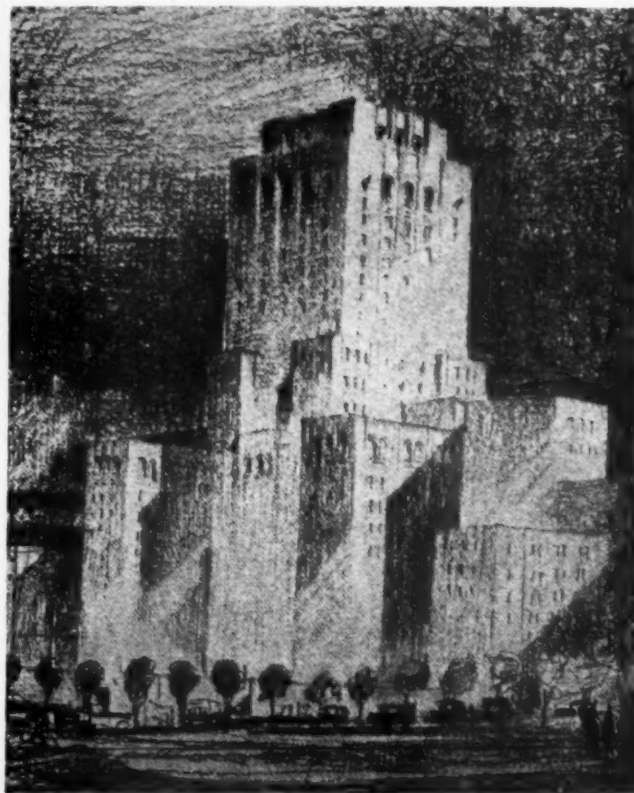
B. N. Duke, a patron of educational and health activities, has donated \$25,000 to the Lincoln Hospital, the colored hospital of Durham, for the purpose of building a new nurses' home.

NEW YORK STATE PSYCHIATRIC INSTITUTE AND HOSPITAL PLANS COMPLETED

Ground is to be broken next month for the New York State Psychiatric Institute and Hospital which, from the standpoint of unusual construction and operating features, is one of the most interesting of the buildings of the Columbia-Presbyterian Medical Center, New York.

State Architect Sullivan W. Jones, has submitted to the Joint Administrative Board the plans and specifications to be put out for bids before January 1, 1926.

The sketch of the structure, shown here, is viewed from Riverside Drive. The building is situated on the left of the Presbyterian Hospital School of Nursing on the right. The building will be twenty stories; the ten on the cliff overlooking Riverside Drive will contain the hospital portion and the ten above, which are on the same level as the other medical center buildings, will comprise the institute. The hospital portion of the build-



The proposed Psychiatric Institute and Hospital, one of the units of the Columbia-Presbyterian Medical Center, New York.

ing is thus placed below the cliff so as to afford patients more quiet and isolation from neighboring institutions than would otherwise be possible.

The building is entered on the eleventh floor from 168th Street and Haven Avenue and on the first floor from Riverside Drive. The hospital portion will provide accommodations for approximately 200 patients and also living quarters for certain of the personnel.

An auditorium seating 150 is provided for on the upper level in the institute portion of the building in addition to classrooms for different student bodies, a museum, a library, research laboratories and other especial equipment for physicians studying in the institute. All the principal facilities for clinical treatment and diagnosis are provided for, including eye, ear, nose and throat services and a dental department. The total cost of the building will be approximately \$1,600,000.

The primary object of the institution is research into causes and treatment of mental disease. It was organized by the State Legislature in 1920, and it was decided by the State Hospital Commission that the Medical Center offered the greatest opportunities for fulfilling the law's requirements.



HOW OTTAWA IS SOLVING ITS HOSPITALIZATION PROBLEM

By Edward F. Stevens, F.A.I.A., Stevens & Lee, Architects,
Boston and Toronto

THE vision of the medical staffs of the Protestant General Hospital and of St. Luke's Hospital, Ottawa, Ont., for an amalgamation to relieve the unsatisfactory hospitalization of the city was realized in the erection of the new \$3,500,000 Civic Hospital.

In selecting a site it was necessary to have enough land available for future expansion and, at the same time, a location easily accessible to the medical men and patients, as well as one that would be in the path of the city's normal growth. Thus a site of twenty-five acres about two miles from the Parliament buildings, upon the highest land in Ottawa, was finally chosen. On the south it faces the Dominion experimental farm, and on the north overlooks the distant Laurentian Mountains.

After careful consideration from the standpoint of economy of construction, maintenance, and conservation of human energy, a six-story building, housing over five hundred patients, was erected, with separate buildings for nurses' residence, employees' quarters, kitchens, laundry, heating plant, and the garage.

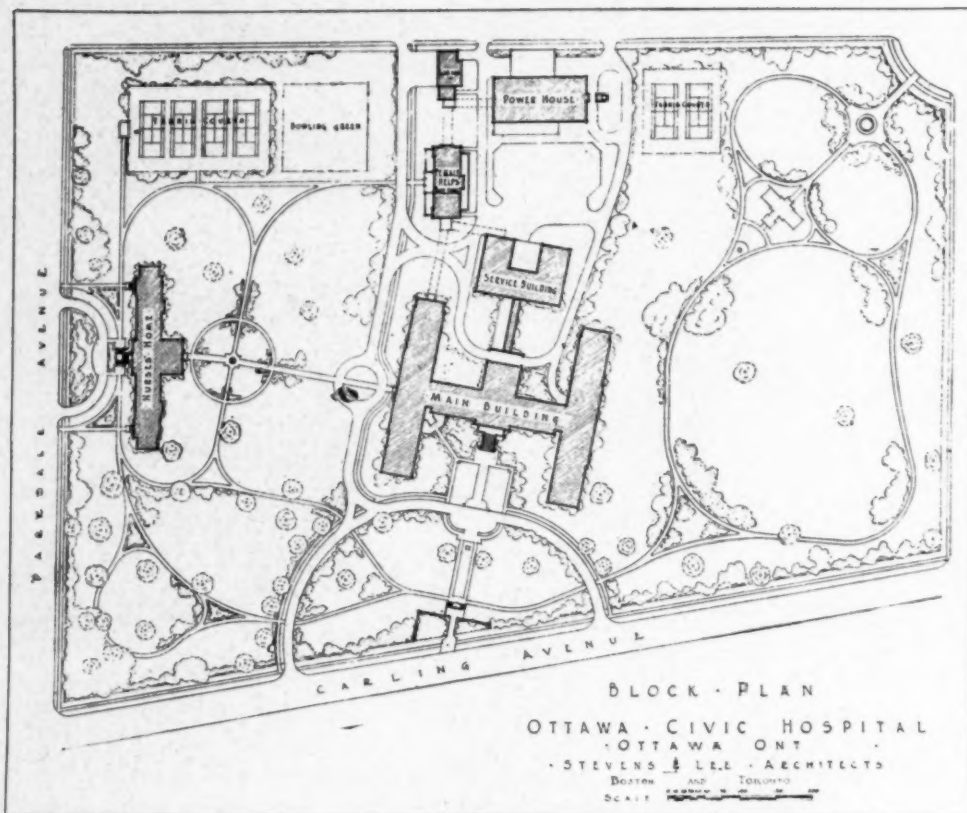
The main pavilion is in the form of an H, with the open courts facing north and south. The service portion is located at the crossing of the main corridors, making two distinct units on each floor. The administrative offices, instead of being located in a separate building, are on the first floor of the connecting pavilion and are reached by a drive approaching the building from Carling Avenue. From this first floor level, the dining and other rooms in the service building are reached by a connecting corridor extending over the ambulance entrance, which is at the ground floor level to the north.

The out-patient department, with entrance from the front and side, is located on the ground floor, and con-

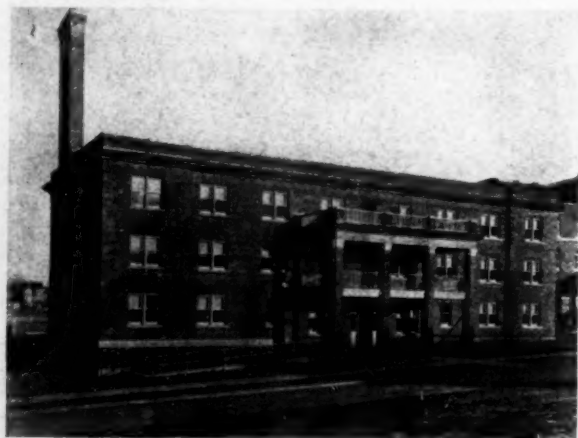
sists of the various sections for surgical and medical treatment, such as the x-ray and physiotherapy departments and rest rooms. On this floor are located the psychiatric section and a small isolation department, each complete for functioning independently. At the center and on the north is the admitting department for all patients. This department is reached through an enclosed portecochère, and consists of admitting rooms for men and women and a special admitting room for the maternity department, with special lift to the maternity floor. Connected with this department are two detention wards.

Maternity, ward and private patients are provided for in this main building, with separations by floors or horizontal divisions. The largest ward is planned for sixteen beds, with alcoves for four beds each, formed by low screens, affording greater privacy, and decreased danger from the spread of contagion. A separate section is set apart for the care of venereal diseases. There is also provided a children's department, with special baths, playrooms and airing balconies.

The maternity department, consisting of eighty beds, occupies one complete story and has separate delivery rooms and nurseries for the private and ward patients. With the two service units and the lateral sub-divisions, the results of separation and segregation are accomplished the same as in separate pavilions. One entire floor and a large portion of another are devoted to the care of private patients, with single rooms and rooms en suite. All rooms have separate hospital lavatories, and suites of rooms have toilets and baths. On each floor above the first there are two solariums and three large airing balconies, making it possible for all patients to have access to the open air.



The sixth or top story contains the operating and surgical department, consisting of four major operating



Female help's building

rooms, an eye-operating room and a plaster room, together with service, sterilizing and work rooms. The



Laundry

natural lighting for operating rooms is by means of a high vertical sash. Two open air wards are provided on this floor with service rooms connected. In the towers are located the heating and ventilating fans, as is the plant for distilling the water used for surgical and drinking purposes throughout the building.

Special care has been given to provide every convenience for the care of the patients. Every ward and room is provided with hot and cold water, and distilled, iced drinking water is available in every part of the building. The serving kitchens are placed in close proximity to the patient and yet far enough away to prevent the carrying of unpleasant noises and odors. Nurses' call systems have been installed at the head of every bed with silent (light) call at all nurses' stations and service rooms, and a doctors'

paging system for quickly locating any member of the staff, is conveniently located. Electric clocks and surgical dressing rooms with equipment on every floor are some of the other features. The floors, wall colors, lighting fixtures and furniture have all been chosen with consideration for the comfort of the patients. The same consideration has been given to the arrangement and furnishings of the nurses' home and the employees' quarters.

In the service building directly north, and connected with the main building by bridge and tunnel are located the main kitchen for the entire group, the storage rooms for all supplies, the dining room for the staff, nurses



Service building

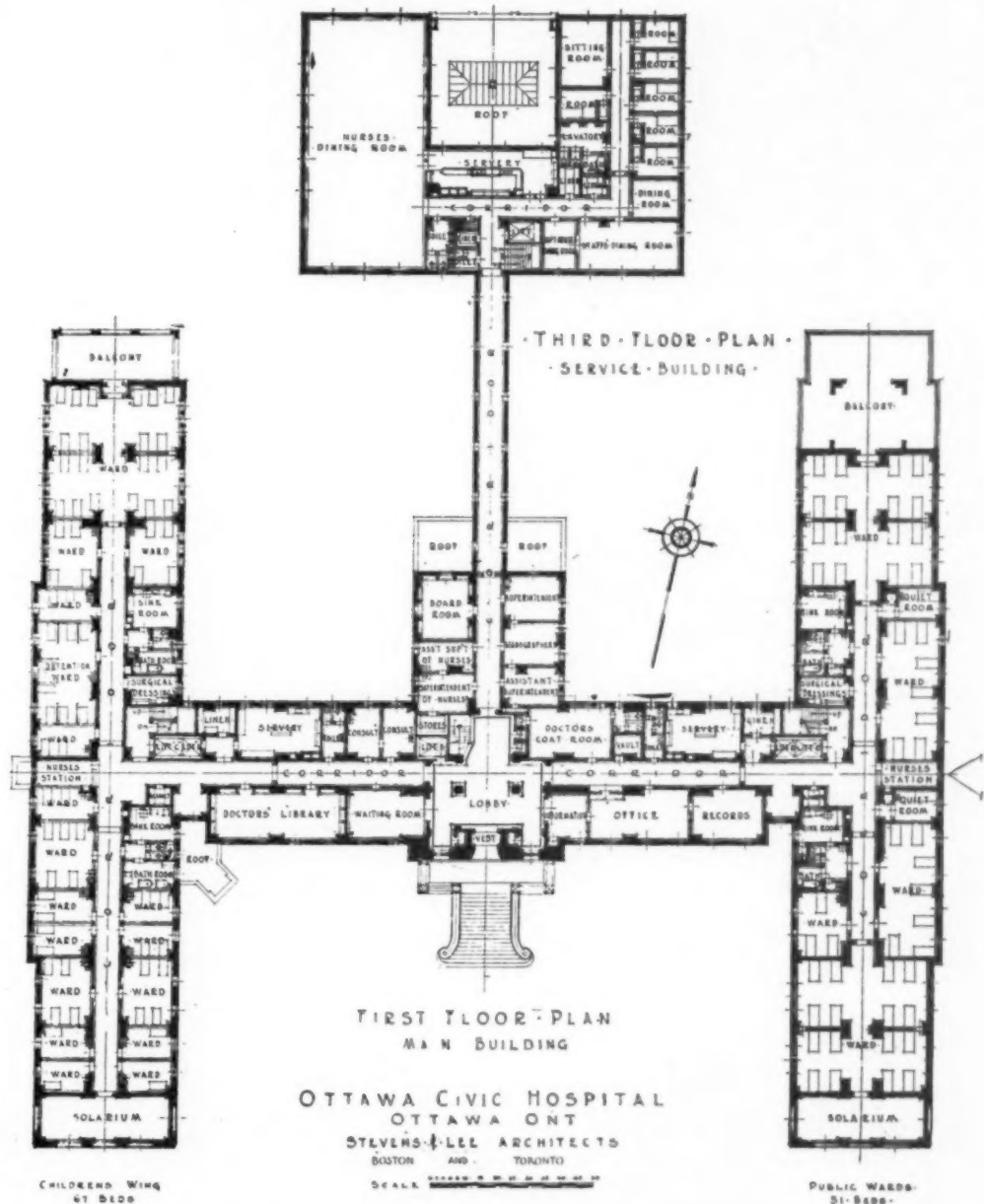
and servants, and, on the upper floors, the quarters of the resident staff.

The contour of the ground was such that it allowed the delivery of supplies practically on the level of the basement of the main hospital building, access to the building being through a tunnel and thence to the service lifts (A on plans), which connect directly with the serving kitchens on all floors.

The main kitchen on this level extends through two

stories and the rooms on the mezzanine floor are used for kitchen and other supplies and for linen and sewing rooms. The main kitchen is equipped with every facility for preparing food in the quantities needed. A bakery with brick ovens and modern machinery adds greatly to the conveniences. The main cold storage is on the kitchen level with large additional cold storage on the floor below. The heating department and laundry are housed in a separate building but connected with the main building by a tunnel, which serves not only for the steam, water and electric mains, but as a connection to the laundry and supplies. The heating of the building is by forced circulated hot water. The laundry machinery is of the most modern type while a garbage and refuse incinerator forms one of the important adjuncts to the mechanical equipment. This building also provides quarters for the male employees with single rooms for forty men.

Located between the power plant and the main structure is the building for the female employees, providing recreation rooms and single rooms for seventy-two people. The nurses' residence, located to the west on Parkdale Avenue, provides not only single rooms for 230 nurses but lecture and demonstration rooms, parlors, entertainment and living rooms all conveniently arranged. This building connects with the main group by a cross tunnel.



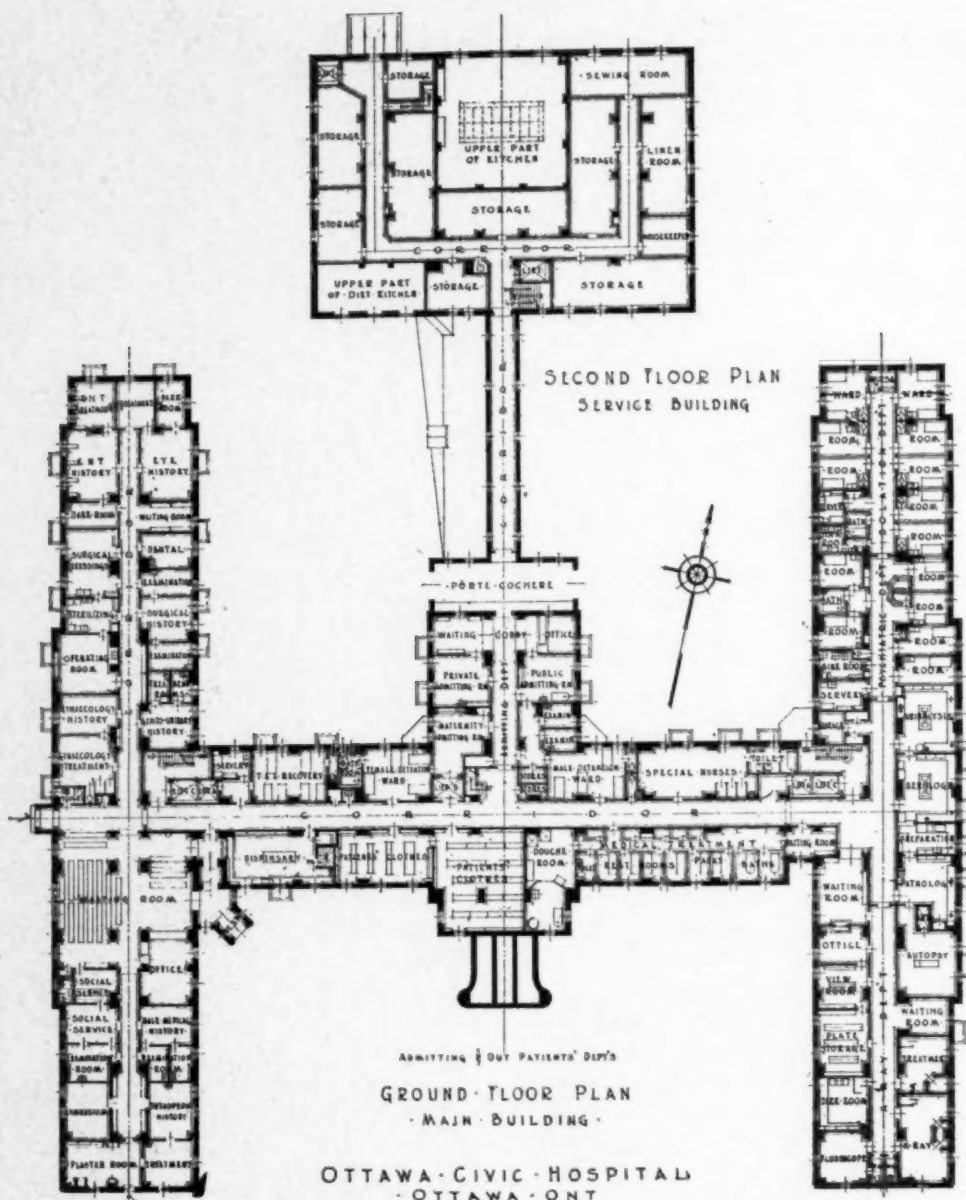
All buildings are of fireproof construction, with steel and concrete forms. The exterior is of red brick with sandstone trimmings and is simple but dignified in design, without undue ornamentation to detract from the beauty of the architecture that has been so happily chosen as the most adapted to the site and surrounding premises.



Waiting room, out-patient department



One of the kitchens



employees of the hospital, medical staff, nurses, male and female help has been given special consideration and provided for through a thorough study of the conditions and layout of the hospital block.

The landscape gardening, which has added beauty and comfort to the practicability of the hospital through the well-studied setting of shrubs, walks and flowers, is the result of the wish of a donor, who, in giving \$200,000 for this purpose, expressed a desire that the patients be given the pleasure of enjoying what has always been a pleasure in his life.

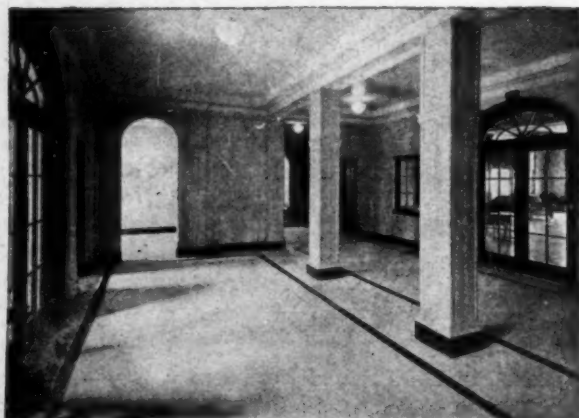
Spacious lawns and winding walks which, although seeming to meander throughout the grounds, have been thus placed from the standpoint of utility as well as of pleasure, are for the use of both patients and hospital personnel. With the addition of shrubs and trees, the grounds appear more like a park or a country estate than hospital property.

To the rear of the main hospital building, recreational facilities for the personnel have been provided in the form of tennis courts and a bowling green. Here the doctors, nurses and help may spend their leisure moments.

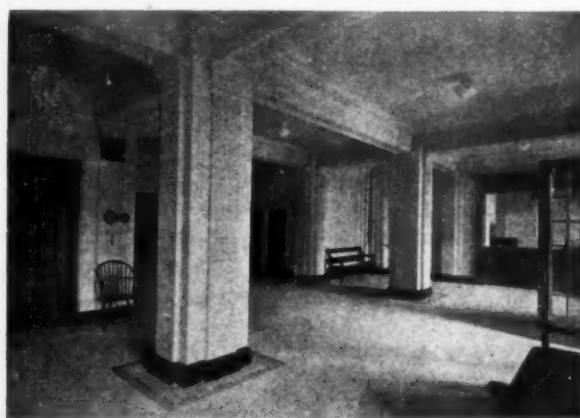
Such an institution is the result of the foresight of the two Ottawa hospitals which, in their desire to improve the hospital situation in the city and to eliminate duplication

of expenses of the two institutions, offered to transfer all of their various assets and properties to the city for the purpose of erecting one large hospital that would best serve the needs of the community in every respect.

As can easily be seen from the foregoing description, the facilities for the accommodation of patients are of the best. Yet, not only are the patients given every possible advantage of service and care but the welfare of the



Lobby of nurses' home



Lobby of the main building

NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, M. A.,
Butler Hall, 402 West 119th Street
New York

THE PRESENT-DAY RELATION OF DOCTORS AND NURSES*

By Elliott C. Cutler, M.D., F.A.C.S., Professor of Surgery, Western Reserve University Medical School, Cleveland

MOST heartily do I agree with Dr. Cutler that "the professions of medicine and nursing agree to a similar purpose: better care of the sick." But that is not all; we nurses want to be intelligent enough to help prevent sickness. We want to be able to translate scientific knowledge into the simple, non-technical language that will be understood by the average, or even the below-average, individual. All too often it is the none too intelligent mother who makes the individual application of the most brilliant discovery of the learned scientist. And who has a better opportunity to teach mothers than nurses, be they private duty, or public health workers?

Dr. Cutler further states: "It is certain that the doctors and nurses not only should be the most mutually helpful groups of individuals, but they must always maintain such a liaison if they wish to succeed and progress." As evidence that Ohio nurses not only agreed, but acted upon this assumption,

I submit the report of the committee of nurse education, Ohio State Medical Association, which appears in *The Ohio State Medical Journal*, May, 1923. The members of this committee and representatives of the various nursing groups spent days in earnest conference and honestly tried to get each other's point of view. There was every reason to believe that the result of the conferences was mutual understanding and good will.

Perhaps it is time to have some more conferences of this sort. I know the nurses are always ready to meet the doctors more than half way.

One suspects that Dr. Cutler is joking when he suggests the possibility of the professions of nursing, and medicine overlapping. Even in the best schools nurses are given so pathetically little real education, that they are constantly obliged to supplement their initial preparation in order to cooperate intelligently with doctors and other health workers.

—C. E. G.

THE greater part of my first ten years following graduation from medical school was spent in hospitals. These years were spent in teaching hospitals where problems regarding nurses and nursing were ever present. For at least two of those years I was a fellow pupil with nurses, and during the succeeding years I have attempted, as a teacher, to hand on to the classes of nurses the knowledge I had accumulated that might be of benefit to them. I have worked for and with practical and visionary leaders of your profession. As a result I can say that if doctors were forced to relinquish all methods of therapy except one I think that one would be good nursing.

I assume that the profession of medicine and the profession of nursing have a similar purpose: better service to the sick. I also surmise that even your most imaginative leader will agree that you do not intend to practice nursing independently of the medical profession. If we accept these obvious statements it is certain that physicians and nurses should be not only mutually helpful but should always maintain a liaison if they wish to succeed

and progress. The two professions are like the legs of an architect's compass, useless unless united.

The profession of medicine is as old as civilization and the profession of nursing one of our most recently created occupations. Yet nursing has always been a woman's birthright, although it has only recently been set aside as something worthy of especial study. The recent and tremendous impetus behind this development seems to be dependent on two factors, namely, the general emancipation of women in relation to the many activities of life, and the necessity for expert assistance of a special type in the development of modern medicine. With the discovery of specific bacteria as the cause of certain diseases, new methods of treatment and study arose that necessitated the employment of trained medical assistants. Nurses were already at hand in hospitals, and it was only natural that great efforts should be made to train them along lines that would permit patients to receive full benefit from the far-reaching discoveries that were being made.

Now nurses have much instruction, a limited daily service, and are relieved of what we might call the irk-

*Address before the Cleveland Nursing Center, April 8, 1925.

some jobs of sixty years ago. There can be no denying the resulting benefits to all concerned. The nurse has been raised to a far better station in life; the profession of medicine has gained a highly trained, effective and responsible ally; the patient has gained an intelligent and capable helper.

This change and development has been steady and rapid. The first training school was established by Miss Nightingale to educate the matrons of hospitals; later, the trustees of institutions saw the wisdom of having successive groups of young people serve their sick, and a quite separate reason for training schools appeared. Later still, the doctors demanded more intelligent assistance and the modern training schools for nurses came into being.

The development of the Lakeside School of Nurses in this city is typical of the development of modern nursing schools in general. Indeed, we can study in Cleveland the entire change, from hospitals practically without organized nursing personnel through the period of granting diplomas to nurses who would stay in the hospital for a given period of time, to the establishment of a real training school of nurses, and finally to the creation of a school of nursing as an integral part of the university.

Demands from the Medical Profession

Modern nursing education has reached this high development within a brief period. We must not, however, look upon this metamorphosis as an experiment nor as the result of the hypothetical ideas of a few people. It has all come about through incessant demands from many quarters. These demands came chiefly from the medical profession.

As time went by the tendency of the medical profession to split up into specialties demanded further training for some nurses. Finally the opportunities for service in the community, as public health and industrial nurses, when the lack of frequent contacts with the physician demands an even greater knowledge of medical matters, led to a fresh demand for an especially qualified and responsible type of nurse, who could work for the first time a good deal on her own responsibility.

All this has led to a persistent demand for greater and more extensive training. It has resulted in more time being devoted to training nurses in the special branches of medicine. And to understand their newer and broader fields, it seemed wisest to give them a fair grounding in the basic facts of the medical profession, in order that they could give more expert service. This has resulted in more hours being set aside for classroom exercises without any lengthening of the period of time devoted to acquiring a complete training. This, in turn, has resulted in a decrease in the number of hours available for training in the practice of the art of nursing.

Where will this lead us to eventually? Are we not already duplicating to some extent in our nursing schools, the medical student's training? Is the order of the studies in the nurse's curriculum well arranged? Are we not trying to cram into three years an education that demands five years? Is all this education necessary? Are we to continue at the same rate and along the same lines? If so, will not the professions of nursing and medicine overlap? Nurses are certainly going faster in their approach to the medical profession than the latter is enlarging its horizon as a whole or changing its curriculum demands. Where are we to stop?

I ask these questions, obvious as they are to all of us, that we may frankly face the issue. No one in your profession can be more interested in your development

than the doctor with whom you come in daily contact. Since you are his chief assistant, he naturally enough wishes to see you as well trained as possible. Moreover, he can visualize your value as a special assistant, whether in x-ray, public health, surgical, anesthesia, or industrial work, better even than you can, since these are the walks of life that he controls. To be sure the doctors themselves have some differences of opinion regarding these matters. Thus, some surgeons feel that a nurse makes a better anesthetist than a doctor, others believe the contrary; some advise the corporations, for whom they are consultants, not to employ industrial nurses, while colleagues may feel the opposite. As a group, however, they are your best friends and advisers.

What worries those doctors, who are the best friends of the nursing profession, is whether the nurses are not, perhaps unconsciously, trying to break away into a separate field, as other medical agencies have. The breaking away from the scope of medicine proper is usually the fault of the profession of medicine; thus Christian Science, osteopathy and chiropractic, as separate units, are really the result of the failure of medicine to visualize and emphasize these forms of therapy. It seems to me as if nurses were also a bit anxious for a similar independence. Just why? I do not believe they themselves know. It cannot be that their independence will enable them to better achieve their aim—better service.

The very thought of such a possibility of separation is unfortunate. I bring this up because I have often been asked whether the profession of nursing was leaning towards the medical profession or elsewhere in its attempts at what it might look upon as emancipation and higher development.

Let us return again to your purpose. Surely it is identical with that of the medical profession—to render better service. Does the modern training school do this? Has its internal construction and curriculum kept abreast of the changes and new demands? Twenty-five years ago it gave a three-year course. It still gives the three-year course in spite of the fact that innumerable new developments have demanded a place in its curriculum. Study for a moment what has happened in medical schools. Fifty years ago two or three years sufficed for the complete training, now all good schools give a four-year course, some five, and a few six years, and the hospital training must follow this. If we are to agree that it is desirable to train nurses to keep abreast of the medical advance, the same general scheme of increasing the period of study must be followed in your schools.

Community Needs Different Kinds of Nurses

But there are still difficulties in that the adjustment to an enlarged curriculum does not simply mean the addition of two years' study. For we must recognize in the beginning that the community we serve needs different kinds of nurses just as it needs different kinds of doctors. Thus, the general nurse and the special nurse should have a training differing in both quality and quantity. I can see no reason why the general nurse should have special training in medical history, surgery, medical laboratory work, dietetics, dispensary, social service, public health and industrial work. And she should have a minimum of class work in the pre-medical sciences.

If the curriculum is well arranged, a three-year course of study should amply suffice to give a thorough training in general practical nursing. Students who wish to work in some special branch of nursing should have this same general training. By taking out of the present jammed curriculum certain elements that may be properly classed

in the field of specialties, and by a reduction in the hours devoted to class work, it should be possible to give better general nursing training. The special nurse can spend as much time after this general training as she desires. The three-year period for a training in general nursing should not be lengthened. And during this period, emphasis should be placed on the practical care of the sick patient.

The chief aims in nursing are to give mental and bodily comfort. Does one need to know much chemistry, bacteriology, anatomy, and physiology to do this? It has been remarked that the present curriculum in many nursing schools is over-full, and that the present and future additions, and if we contemplate progress there will always be more to add, find their place there at the expense of practical nursing. I may be wrong, but I believe practical nursing can only be taught at the bedside by practice, just as we believe surgery should be taught at the operating table. Are there any here who want to be explored by a surgeon who has learned his art from books and lectures? Let us admit he is a better surgeon for knowing much regarding the physiology of the blood, the lungs, and the more important viscera; but if he can only learn this at the expense of practice, I do not want him to meddle in my interior. Is not something the same to be said regarding nursing? Is not the practical side the all important?

Three Years of Bedside Nursing

In view of all this, it would seem advisable that in the first three years training the major portion of the nurse's time be spent at the bedside of patients receiving practical instruction. This should include everything that relates to the sick patient from a responsibility regarding the cleanliness and attractiveness of his surroundings to a sensible understanding of how to feed the individual. This presupposes that the nurse in the ward is the responsible person for all activities that reach the patients. If nurses do not feed sick patients, they are robbed of one of the most valuable aspects of their training. If they do not practice cleaning and making pretty and attractive the surroundings of the sick patient, they will fail to realize a most important element in the rehabilitation of an invalid. Moreover, merely to control these activities is not sufficient. One must practice in order to learn, and certainly unless one has practiced, one can hardly instruct others. Curiously enough, the word service seems now-a-days to have taken on a new meaning conveying a certain sense of degradation. Even so, I cannot visualize any woman with the high ideals of the nursing profession failing to recognize the lasting rewards of service to a sick individual, no matter how menial the task may appear. There will be in all this practical nursing much that appears humdrum, such as, let us say, the making of clinical charts. Similar things occur in relation to doctors during their period of internship; for example, the constant taking of blood counts. In fact, in this instance, I think perhaps the nurses have the best of the doctors, because they at least have the vision of their good work constantly before them. Here again practice is important.

Thus, at the end of three years, a diploma or degree should be given in general nursing. For those who are to specialize, another one or two years work will be necessary.

You will ask how are we to fill satisfactorily the positions in x-ray work, public health work, nursing administration, anesthesia, industrial nursing work, and other special fields, for which there is so much demand. My

answer is that these are specialties, just as x-ray work, hospital administration, anesthesia, and similar activities are specialties for the doctors. It seems to me that the only way to retain good practical nurses and also to have groups of nurses specially qualified for certain fields is to model your scheme on the most satisfactory methods now used in medical education. A nurse who enters one of these special fields expects and demands larger financial rewards than the general body of nurses. She should be willing to pay for it by extra work after she has obtained her nursing diploma, just as doctors entering a medical or surgical specialty put in extra years of study after graduation from medical school. I hope I can see in this new university school here graduate schools of public health nursing, industrial and school nursing, divisions of hospital and nursing administration and teaching, departments of anesthesia, roentgenology and surgery. There may be added classes in medical and nursing history, in literature, and in other subjects calculated to give the future teacher a broad cultural aspect towards her profession. We cannot expect nor do we need such an elaborate training in all nurses.

Specialism is the cry of our day. It is the inevitable result of the rapid and great increase in practical knowledge. No one person can be expert in all fields, and it would be a pity to fail to be a success in general nursing in a vain attempt to learn a little of everything. I can speak with authority only in my own field, surgery. Twenty-five years ago a surgeon was expected to be able to perform any operation skillfully. Can he do so today? Where, pray, can he get the experience that will permit him to examine the heart, brain, kidney, or lung with the same degree of skill that he opens the abdomen? Were he to study and practice in special hospitals where each specialty was practiced by a surgeon of wide repute, he might eventually acquire such skill, but by that time his years for practicing his art would be almost at an end. The same situation is present as regards nurses. A very elaborate education will not yield a commensurate reward.

Common Ground of Appreciation Needed

I fear this has been a difficult matter to cover in a short evening's address. We have been able to touch upon but a few of the more important phases. I hope, however, that even if many of you cannot agree in fact with my premises and explanation, this attempt to depict the present relations of nurses and doctors will bring us all to the common ground of appreciation of each other's good will which, after all, is of a far greater importance than the construction of an ideal curriculum. If the right idea is present, we need not fear for the form of its expression.

If I have expressed what may to some of you appear as criticism of an existing plan of nursing education, I hope you will agree that it has been given with a constructive desire to help and assist you. I am heartily in favor of increasing the quality and quantity of nursing education, but I feel that such advances should take place along slightly different lines. It appears that the education of doctors and nurses have a certain parallelism. Each attempts to give a general education, and also to turn out specialists. A scheme of education for one would seem to offer suggestions of some value to the other.

Headquarters for the International Council of Nurses have been established at Geneva, Switzerland, and Christiane Reimann was recently appointed secretary.

WHY INCREASED EDUCATION FOR NURSES?

By Mrs. John H. Lowman, Member of the Trustees Advisory Committee, Western Reserve University School of Nursing,
Cleveland

IN HIS statement that if doctors were forced to relinquish all methods of therapy except one he would have that one good nursing, Dr. Cutler has paid great tribute to the profession of nursing. These words are especially significant coming from one whose many years of experience with hospitals and nursing enable him to speak with well founded conviction and authority.

This being the case I believe that no preparation can be too good for those who are to continue to justify this statement. On the other hand, it is easy to understand that the increasing pressure of work in hospitals, together with the readjustments necessary to put the education of nurses upon a higher plane, must cause a great deal of hardship to all concerned and no doubt great uneasiness to those who, like Dr. Cutler, fear that the little learning, which is so truly a dangerous thing, will be the result of these efforts.

Path of Greatest Usefulness

However, no one can read Dr. Cutler's address without being convinced of his good will toward nurses and his earnest desire to have them choose what he considers the path of greatest usefulness. Many have been the expressions of appreciation of his attitude on the part of the very nurses, in Cleveland, who have dissented the most strongly from some of his premises and conclusions.

Some one remarked to me once that a university hospital man lives and dies an internist. What the monastic orders represent in religion, he represents in medicine. His ideals are high and his whole attitude is not only that of a teacher but of an idealist. His poor are the poor of clinics and hospital dispensaries. When he speaks of private duty nursing he thinks of the well-to-do classes and of expert medical care. He has a world of his own and the scientific life of that world is of a very high order, as is his own great usefulness and worth. When he thinks of the education of his medical students his attitude is one of fraternal benevolence. I wonder if there is anything more beautiful in the attitude of a great teacher of medicine than his desire to pass the torch on fully lighted to those who follow him.

But when it comes to the nurse, say what he will, he sees her either as a permanent part of a hospital mechanism or as the able aid of his distinguished confrères in homes where all the main factors of safety are assured. In spite of the word "profession" which he has accorded her, he still truly believes in his heart that hers is a manual and vocational occupation and should remain so. But here precisely is where it seems to some of us that he falls into a grave fallacy. For if an informing mind and a fine spirit stand behind the practice of nursing this occupation becomes an art—one of the finest of arts.

For the acquisition of a fine art there must be education and practice—strong education and constant application of the principles that education makes clear. It is precisely with the kind of nursing that remains on the level of a mere occupation, because of the lack of knowledge and the inspiration that knowledge brings, that physicians have a just cause for quarrel, even when they least understand the causes of their dissatisfaction.

Physicians have ever been dissatisfied with the result

of merely apprenticeship training for nurses, even though the majority of physicians have constantly endeavored to keep nurses in the category of apprentices rather than that of students. The story of the systematic fight on the part of nurses consecrated in spirit to the task of rescuing the sick from the care of women of inferior education and attainment can be touched upon very lightly here.

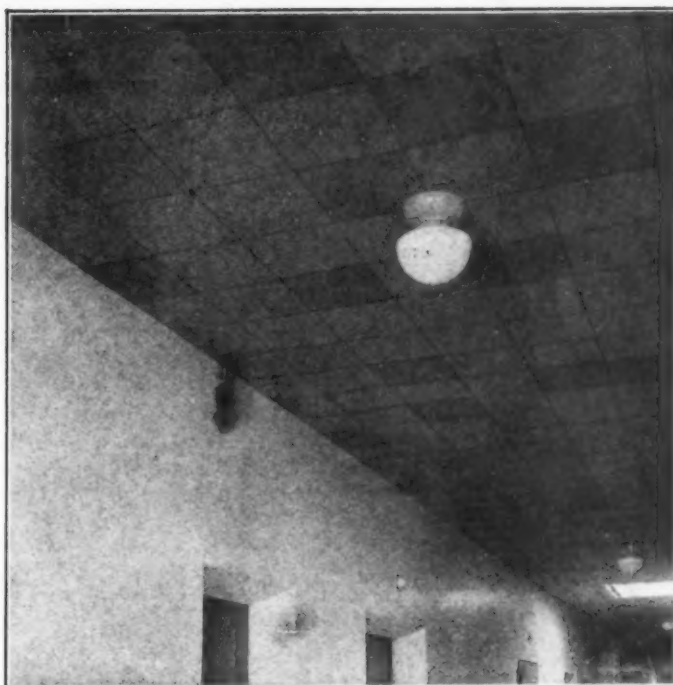
State registration for nurses, improvements in methods of teaching, and improvements in the matter of better physical conditions for nurses have been unnecessarily difficult to accomplish because of the inertia and lack of information on the part of the public, and because each improvement in the nurse's education and environment has necessarily cost the hospital time, money and the inevitable confusion incident to readjustment. The acute need of the hospital for emergency service has always had the effect of concentrating upon it the greater part of the attention of those responsible for the nursing care of its sick. But is it reasonable to suppose that in this day when youth is flocking more eagerly to the universities than ever before, and when hundreds of attractive vocations are opening up for women where ten were known only a few decades ago, we can best serve our purposes by recruiting nurses from the ranks of those who are untouched by ambition and aspiration.

Problem of Attracting Desirable Students

An apprenticeship system will no longer attract the best material, and we need the best human material with thorough education and training. One of the big problems is that of getting the most desirable and forward looking women into our schools of nursing, so that we may provide more adequately for the care of the sick and the wider distribution of the benefits of medicine and hygiene. We do not wish to pursue a method that will turn the desirable candidates into other fields and leave us with material of lesser strength for it is only the best with whom you and I wish to entrust the care of our sick.

The bedside care of the sick seems to many of us to be the one type of nursing where the greatest skill, wisdom and resourcefulness can come into play. Think of the opportunity afforded by the continuous observation of the patient, of which Dr. Emerson once spoke so inspiringly to nurses. What will the nurse make of that opportunity if she is unprepared by education and unquicken by knowledge? Can anything less than education and a fine instinct give her the realization that the power within the patient to help save himself must be cherished, and succored by every attention that skilled nursing can give? Can anyone doubt that the bedside care of the sick is the key position, the one in which the nurse may truly become the fellow worker of the physician?

We need large numbers of the very best women to help us meet the many difficulties of hospital readjustment. We do not want "seconds" but "firsts" in every sense of the word. Carolyn E. Gray spoke wisely when she said, in a recent address before the graduate nurses of Virginia, who have already raised among themselves twenty thousand of a twenty-five thousand dollar fund with



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When using advertisements see Classified Index, also refer to YEAR BOOK.

which to help establish a chair of nursing education in the State University of Virginia: "I beg of you to remember that the finest by-product of the highest type of education is a comprehensive and sympathetic knowledge of human need, and a willingness to sacrifice oneself to meet that need."

What a reward for the oldest of woman's occupations if we say that it must content itself with little better than apprenticeship training in an age when education is attempting to lay a groundwork for all types of usefulness for whose exercise men and women fit themselves. And how very strange it would be to suppose that, if a nurse were to be educated for one branch of work alone, in the present-day temptation of change she would remain in one place at one type of task. The human being is responding as never before to restlessness and the temptation of change, and there is no greater incitement to restlessness than superficiality. Therefore, we need to get a high type of woman and give her a thorough education and a genuine conception of her profession.

Probably no nurse ever strove more painstakingly and with greater ardor to improve the standard of nursing education than did Isabel Hampton Robb. Among some papers found in her desk after her death were notes of an unfinished address to be given at a jubilee meeting of the fiftieth anniversary of the founding of the first school of nursing. In these notes there appeared the following phrase:

"Fourteen years after the Nightingale School was established in England the first regular training school for nurses in connection with a general hospital was founded at Bellevue Hospital, New York, on much the same lines as the one in England. Hence, like her English sister, the trained nurse of America is the child of the public and not the outcome of medical development; in fact, she may be said to have been thrust upon the medical profession before modern medicine had developed. In view of these facts, then, whatever the modern nurse may have to her credit of praise or blame, you of the laity must recognize her as your own product, largely the result of your own bringing-up and of the opportunities you have afforded her."

We of the public are greatly concerned with the promotion and support of schools and universities, but until quite recently we have not acknowledged our responsibility toward schools of nursing, which have had to face a large measure of poverty and misunderstanding largely because of the apathy of the public. I am sure that no one will rejoice more greatly than Dr. Cutler when these trying days of transition are passed and when really good schools shall have had a chance to do their part and make their contribution.

Japanese nurses are planning to form a national nursing organization. Iku Todoriki, vice-superintendent, Training Institute of the Japan Central Red Cross Hospital, Tokyo, and Mrs. Shin Inouye, honorable secretary of the Red Cross Society, Tokyo, have made a study of the nursing organizations in America and Europe.

Anagrams, the new monthly house organ of the American Nurses' Association made its first appearance in October. The aim of the publication is to keep the 51,000 members of the association in closer touch with each other. The headquarters are at 370 Seventh Avenue, New York.

A course of lectures on professional subjects is being held this winter by the Presbyterian Hospital Alumnae Association of Philadelphia.

EDITH CAVELL

One of our correspondents sent us a picture of Edith Cavell with the following note:

"When I was in London last October, they were having a sale for the Edith Cavell Homes of Rest for Nurses, little artificial violets and cards being sold in the hotels, railway stations, etc.

"I was informed that this organization, which works under the general direction of the Red Cross, maintains in various parts of England rest homes for over-worked, sick, unemployed or superannuated nurses. These homes are entirely free but nurses are expected to make such



I have no fear nor shrinking. I have seen death so often that it is not strange or fearful to me. This I would say, standing as I do in view of God and eternity, I realize that patriotism is not enough. I must have no hatred or bitterness toward anyone.

Edith Cavell

contribution as they can to the general fund for the homes. I was informed that the homes are well patronized and that they have done much to restore to health and usefulness a considerable number of nurses committed to their care.

"The idea seems to me to be well worth considering with a view to adaptation to our needs in this regard in America."

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DIETETICS AND INSTITUTIONAL FOOD SERVICE

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ADVANTAGES AND DISADVANTAGES OF THE THREE TYPES OF DIETARY DEPARTMENTS*

By Ruth Wheeler, Ph.D., Professor of Nutrition, State University of Iowa, Medical College,
Iowa City, Ia.

SINCE the organization of the American Dietetic Association eight years ago we as individuals and as a group have been deeply conscious and appreciative of the growing cooperation of hospital activities. Last year at our national meeting Dr. Malcolm T. MacEachern gave us an exhaustive survey of our field as seen in the light of his continent-wide survey of the whole of hospital organization. This year Dr. William H. Walsh has offered us invaluable cooperation and last week at our meeting in Chicago both he and President Gilmore gave us help of which we shall make practical use in the development planned for the coming year. So it is with more confidence than we would have felt a few years ago that we are attempting to follow out another suggestion that has emanated from this organization, namely, that we standardize our job. What I am to say does not constitute a finished or authorized report; it is only a start.

Two Types of Organization

The types of organization one most often finds in hospital feeding departments may be considered in two groups: those with a divided organization and those in which the whole feeding problem is the responsibility of one person or one group under the direction of the superintendent, on the one hand, and of the doctors on the other. Of each of these types at least two varieties exist and one can easily think of examples of all four kinds of organization in which the whole problem is satisfactorily taken care of.

Type 1. Divided Organization

- (a) Dietitian is an administrator; special diets by doctors and nurses
- (b) Dietitian is a scientist, administration by chef, steward, etc.

Type 2. United Organization

- (a) Highly centralized organization
- (b) Committee organization with chairman

Any one of these four kinds of organizations may be successful; every one of them has proved successful; successful examples of all of them can be remembered at this minute. But hospital organization is developing rapidly and what hospital executives are asking of the

American Dietetic Association is that we look forward a few years and visualize the kind of organization that seems to us with our somewhat limited experience likely to be most useful in the future in the average general hospital.

We find we have to go back constantly to contemplation of our reason for existence. What is the ultimate purpose of the hospital feeding machine, whatever it may be called? Surely it exists for two purposes: (1) To see that patients, nurses, doctors, the whole personnel have a diet that is nutritively adequate, properly prepared and attractively served; (2) to develop and keep in motion an organization that will accomplish the above with minimum cost.

These purposes are mutually interdependent. One cannot say either is more important than the other. To serve an adequate and attractive diet at exorbitant cost leads to disaster and to have a perfect machine serving food seriously lacking in any essential leads to another variety of disaster which is to most people less spectacular but no less serious. It is somewhat like the case of the man who taught his horse to eat bran exclusively but had to report that the ungrateful animal had up and died on him.

Those being the reasons for the existence of the feeding department, that organization will be best which secures expert knowledge in every part of the work, and allows the most direct possible action in every part.

One Person Responsible

Somebody who is competent must know (not think or feel pretty sure) that the general diet served to patients and that served to the personnel conforms to the known requirements for adequate nutrition, cooked in such a way that it can readily be digested, and served in such a way that it is appetizing. The whole force must be organized in such a way that the person responsible can get the most direct possible action if the buying or the cooking or the serving defeats the purpose in view.

It is a great advantage to have the responsibility for efficient buying of food and for the serving of attractive meals in the same hands. If general diets prepared in the main kitchen were as right, nutritively, as the so-called special diets much waste of material and energy

*Read before the dietetic section of the American Hospital Association, Louisville, Ky., October 20, 1925.



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would be avoided. The same sort of increased efficiency would result if the diet kitchen were run on a scheme as efficient as the best main kitchens.

But the benefit of knowledge in every phase of the work precludes the possibility of putting the whole responsibility in the hands of one person, at least in the average general hospital that we are considering. The field is too broad, too diversified. There may be superhumans who could inspire and direct and control it all in a highly centralized organization, but such people must be few and rare for most of us have never met one, man or woman.

The best chance of success would seem, in the large hospital at least, to be a unified department, managed by a group of specialists operating under a chairman of sufficient intelligence to recognize her own limitations and to inspire and encourage progress in the group as a whole; of sufficient accomplishment in some part of the field to have the confidence of her own group and of the colleagues and superior officers in other lines. To get the benefit of all the expert knowledge the institution can afford, it is necessary to get not only a group of specialists, but the continued help and direction of all the specialists in other lines. The administrative dietitian is the executive officer of the superintendent; the therapeutic dietitian, the lieutenant of the physician; the nurse and the dietitian must pool their knowledge in every special feeding case. In the long run success is impossible unless there is quadrilateral cooperation of the superintendent, the doctor, the nurse and the dietitian.

The small hospital cannot have such a group; it needs a paragon. But young dietitians with broad academic training that makes it easier for them to gain understanding of other people's problems, with careful training in a large diversified hospital in which all types of problems are generously shared with them, can tackle a diversified problem with great hope of success, provided their colleagues and their superiors all give them the generous support and help they are now getting in many hospitals.

Dr. C. C. Burlingame, executive secretary, Joint Administrative Board, Columbia Presbyterian Medical Center, New York, told us last week that we and the rest of the personnel of hospitals must remember that we are the eleventh member of the team, useful, even necessary, but in institutions which have long gotten along with a team of ten the introduction of the eleventh necessitates a readjustment all round, and requires patience on the part of everybody.

Most important of all at this critical stage of hospital development is it that general hospitals make generous provision for the training of dietitians and take a real and serious responsibility for making conditions that will encourage the growth of every promising member of the staff.

This last word to hospital executives: If you are satisfied with your dietitian see that she has a chance to grow; if you are not, take steps to develop the sort of dietitian your organization needs.

MINNESOTA DIETITIANS HOLD ANNUAL MEETING

The annual business meeting of the Minnesota Association of Hospital Dietitians, was held November 9 and the following officers were elected for the ensuing year:

President, Winifred P. Howard, Ancker Hospital, St. Paul; vice-president, Lois Hurlbut, General Hospital, Minneapolis; treasurer, Louise Marty, New Asbury Hos-

pital, Minneapolis; corresponding secretary, Harriet Warmington, U. S. Veterans' Hospital, No. 65, St. Paul; recording secretary, Joan E. Boeyink (re-elected), Fairview Hospital, Minneapolis.

The remainder of the meeting was taken up by reports on the Chicago convention by members who were able to attend.

METABOLISM AND DIET IN DISEASE*

Knowledge of metabolism is essential in the treatment of thyroid disorders, diabetes mellitus, and disturbances of nutrition. Basal metabolism is secured by having the patient rest from one-half hour to one hour and abstain from food for twelve to eighteen hours. The basal rate is a very constant figure in a group of the same sex and age.

Exercise has a profound effect on the metabolism. Sitting up in bed will increase the metabolism 10 per cent above the basal rate. Work will increase the metabolism from 100 to 300 per cent, depending upon the degree of exertion. A severe chill can increase the metabolism 200 per cent. Increases of temperature within the body are accompanied by an increase in the metabolic rate. A temperature of a 100 degrees F. may cause a 40 per cent increase in the metabolism.

Treatment of diabetes now stresses what material is being burned in the body. Enough calories are given so that the sugar will be eliminated from the urine and reduced in the blood and at the same time prevent the formation of acid bodies. Work has been done in order to determine how much glucose is necessary to allow a complete breaking down of a definite amount of fatty acids. In practical work, ketogenesis of total metabolism is closely allied. The metabolism in under nutrition is low. In over nutrition, there is very little change in the metabolism.

The thyroid gland exerts a marked influence on the metabolic rate. From the standpoint of metabolism, diseases of the thyroid can be divided into three classes; those that increase the metabolism, those that decrease the metabolism, and the cases that have no effect on the metabolic rate.

Certain of the blood diseases frequently show a rise in metabolism. The metabolism increases with an increase in the temperature of the body.

DISPOSING OF CHIPPED DISHES

The superintendent of a small hospital in the Rocky Mountain district does not permit the use of any china or glasses that have been chipped. Chipped glasses may, and often do, cause patients to cut their lips, while chipped dishes are a source of danger in that it is very difficult to be certain that germs will not lodge on the chipped portions. For these reasons he has a daily inspection in which all such dishes are sorted, sterilized and then given to such charitable organizations as the Salvation Army, Rescue Mission, and the city mission.

DRESSING UP WOMEN'S TRAYS

The dietitian of a Mid-West hospital has learned how to please women patients and also to make them speak well of the hospital to their friends by serving good food and especially new dishes. For this reason she spends much of her time trying out new food combinations of dietetic value and of dainty, appetizing appearance.

*Abstract of paper by Dr. Max Hoffman, read at meeting of Hospital Dietetic Council, Louisville, Ky., October, 1925.



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SOME WAYS TO RELIEVE THE MONOTONY OF THE LIQUID DIET

By Lulu G. Graves,
New York

THE insipid and monotonous liquid diet much talked about by doctors, dietitians, nurses and patients, is like the weather Mark Twain deplored that everybody talked about but nobody did anything about. The same old routine continues to be served *ad libitum*.

In cases requiring a special diet the idea in prescribing and planning the diet is to make it fit the patient's needs, but in cases requiring a liquid diet, little or no attention is paid to the patient's needs. In some instances, liquids are given merely as a stimulant to enable the patient to pass through a critical period, probably a period of only a day or two in which the lack of food is not so serious as would be the tax of solids on the digestive organs.

How Flavor Improves Liquids

In other instances, the patient requires a highly nutritious diet that must be in liquid form, as in diseases accompanied by high temperature, or he may not be able to utilize food taken at regular meal hours in sufficient quantities to meet his physical requirements, and this is supplemented by between meal nourishment. Again, a patient may have no desire for food and refuse to make the necessary effort to eat his meals; an attractive liquid with a piquant flavor may stimulate his appetite and induce him to eat other foods, regardless of the effort; or it may serve as a means of providing the body with the fluid it requires and that it might not otherwise have. Conditions varying so widely call for special consideration, implying thought and care, but not necessarily a great deal of additional work. Milk, for instance, is high in food value but is bland in flavor, and one may soon tire of it, especially if ill and the appetite not normal. Below are ten ways of serving milk that have all the virtues of the time-worn eggnog but lack its vice, monotony.

The beaten egg with sugar and a pinch of salt, just as it is usually prepared for eggnog, may serve as a foundation for the following mixtures to be added to a glass of milk.

a—The juice of half an orange, 2 tablespoons of grape juice, prune juice or the juice of any other fruit that has been cooked or that will not curdle the milk.

b—One quarter cup of coffee to which has been added a few drops of vanilla. (This may be prepared from coffee remaining from breakfast and kept in the refrigerator until wanted.)

c—Two tablespoons of chocolate syrup. It is a convenience for the dietitian and housewife to keep chocolate syrup on hand for cocoa and other drinks as well as for flavorings.

d—Mexican chocolate. This is a combination of the chocolate syrup, coffee and milk into which a small stick of cinnamon is dropped while heating. When ready to serve remove cinnamon and add a spoonful of whipped cream.

Any of the three last named may be served hot or cold. If served cold they are improved by putting them into a glass jar and shaking vigorously; if too rich the egg mixture may be divided and used in two servings.

e—Café au lait is a mixture of equal parts of strong coffee and milk.

If a patient has difficulty in digesting fluid milk, there may not be the same difficulty with dry milk, and the foregoing combinations may be prepared with dry milk. Other patients may find the value of the diet enhanced by this means.

A liquid diet implies a condition of the digestive tract, that calls for minimum exertion. In dry milk, during the process of drying, the fat emulsion is broken up and casein reduced to a fine flocculent precipitate, thus making both elements more readily digested. Then, too, it is a standardized product and with ordinary care in dissolving produces uniform results, that are not always obtainable with fluid milk. Pediatricians have found dry milk to be a solution to their problems. In Abt's "Pediatrics" we find this statement by Brenneman: "The advantages of dried milk are so obvious that it has become increasingly popular within the last few years. That dried milk is more easily digested by the baby that does not digest fresh milk satisfactorily, or by any baby, can be doubted or denied only by those whose prejudices have not permitted them to use it. Just as boiled milk is easier to digest than fresh milk, so dried milk is easier to digest than boiled milk, and probably for the same reason."

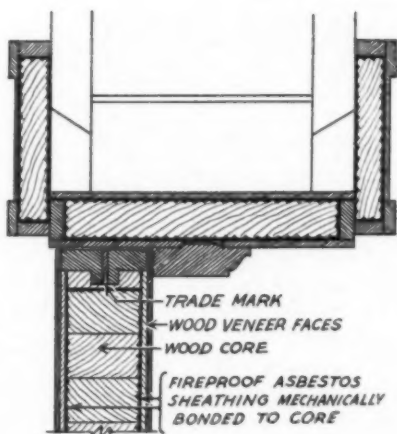
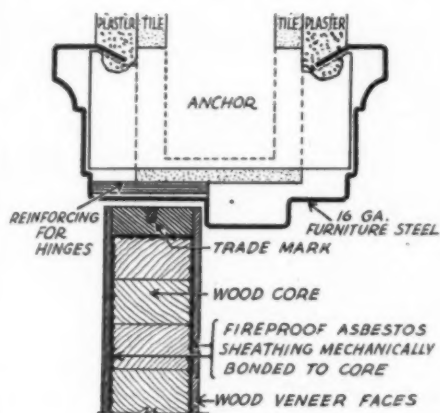
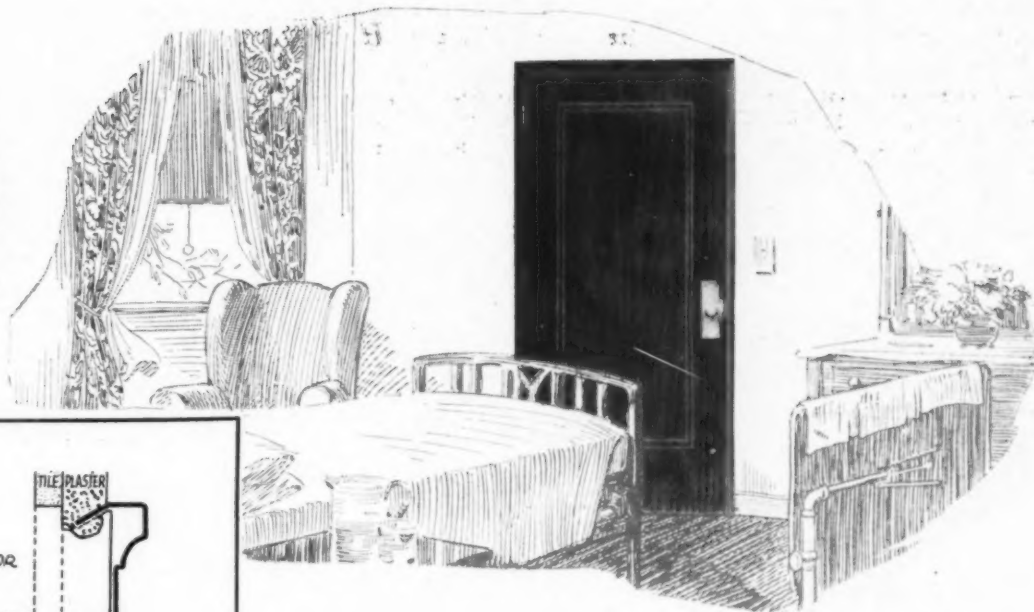
A liquid diet prescribed for stimulation only is rarely required for more than two or three days, but this is no reason why it should not have a pleasing flavor and some variety. The broths may be made more palatable by cooking celery leaves or the outside stalks of celery with the meat, then straining off the broth. Gruels may have a tablespoon of broth, beef juice or grape juice added. If nutrition is the object, chocolate and fruit juices may be combined with milk and eggs in innumerable ways, besides those above mentioned, both as drinks and frozen mixtures. Cream soups made of vegetables, strained through a fine strainer, or mashed finely, are excellent means of providing nourishment when the particles of solid food are permissible. The water in which the vegetables are cooked may be used for the white sauce, thereby improving the flavor. If cream is substituted for milk, the caloric value will be increased and the nutritive value will be otherwise changed. Custards made of cream are valuable and here, too, chocolate and fruit juices may be utilized.

Gelatine as a Supplementary Protein

Gelatine as a supplementary protein and as an aid to digestion may be used to advantage in these diets, one-half teaspoon to one serving of broth, gruel or orange juice and the proportion of one tablespoon to one quart of milk.

In both medical and postoperative cases, the liquid diet is usually followed by a soft diet. Considering the personal element is essential in serving liquid and soft diets as well as in other special diets, not all patients, and certainly not all conditions, will permit of every suggestion on this list, but there are enough things from which to select to make unnecessary the usual tiresome uniformity of service to which everyone objects. The diets may be used for postoperative patients, and gastrointestinal, typhoid or other conditions requiring easily

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digested, highly nourishing foods that are well assimilated. We have approximately one hundred recipes suitable for this purpose. Following are a few suggestions for liquid and soft diets.

LIQUID DIET

a—When stimulants only are required:

1—Broths—

Chicken

Lamb

Beef

Beef tea

2—Clear Soups—

Soups with all solid food strained out and not highly seasoned

3—Beef Juice

4—Gruels, strained—

Oatmeal

Oatmeal caudle

Farina

Wheat cereals

Rice

5—Fruit Drinks—

Orangeade

Lemonade

Grape juice

Loganberry juice

6—Coffee—Tea

b—When nutriment is the chief requisite:

1—Milk in various forms—

a—Eggnog

Chocolate

Coffee

Fruit juices

b—Milk Shakes

Chocolate

Coffee

Fruit juices

c—Mexican chocolate

d—Café au lait

e—Frosted drinks (with ice cream)

f—Partially digested milk

Peptonized milk

Junket

2—Cream Soups—

Peas

Potato

Carrot

Spinach

Tomato

3—Frozen Desserts—

Ice cream made of custard or cream

Ices made of fruit juices

Sherbets made of milk and fruit juices

4—Custards

c—When used to stimulate appetite:

1—Drinks

2—Frozen desserts

Including the above mentioned, various kinds of punch and more highly flavored frozen desserts, in which are used preserved ginger, mint, charged waters, lime juice, pineapple juice and other piquant fruit juices.

3—Gelatine desserts with no solid pieces of fruit or nuts served with plain or whipped cream.

THE SOFT DIET

In addition to the things prescribed for a liquid diet, a soft diet may include the following:

Toast, if toasted entirely through until dry and crisp

Milk toast (made as above)

Cereals, well cooked. They should be strained if the

digestive organs are in a delicate or deranged condition. Oranges

Apple sauce, apple snow or baked apples with skin removed

Prunes, strained; soufflé or whip using egg white or whipped cream

Rice or tapioca pudding thoroughly cooked.

Eggs, soft cooked, poached or coddled.

When the patient is able to take solid food, the following foods may be added gradually but it is better to add only one each day:

Broiled or baked fish

Creamed chicken

Baked potatoes

Rice, well cooked

Sweetbreads

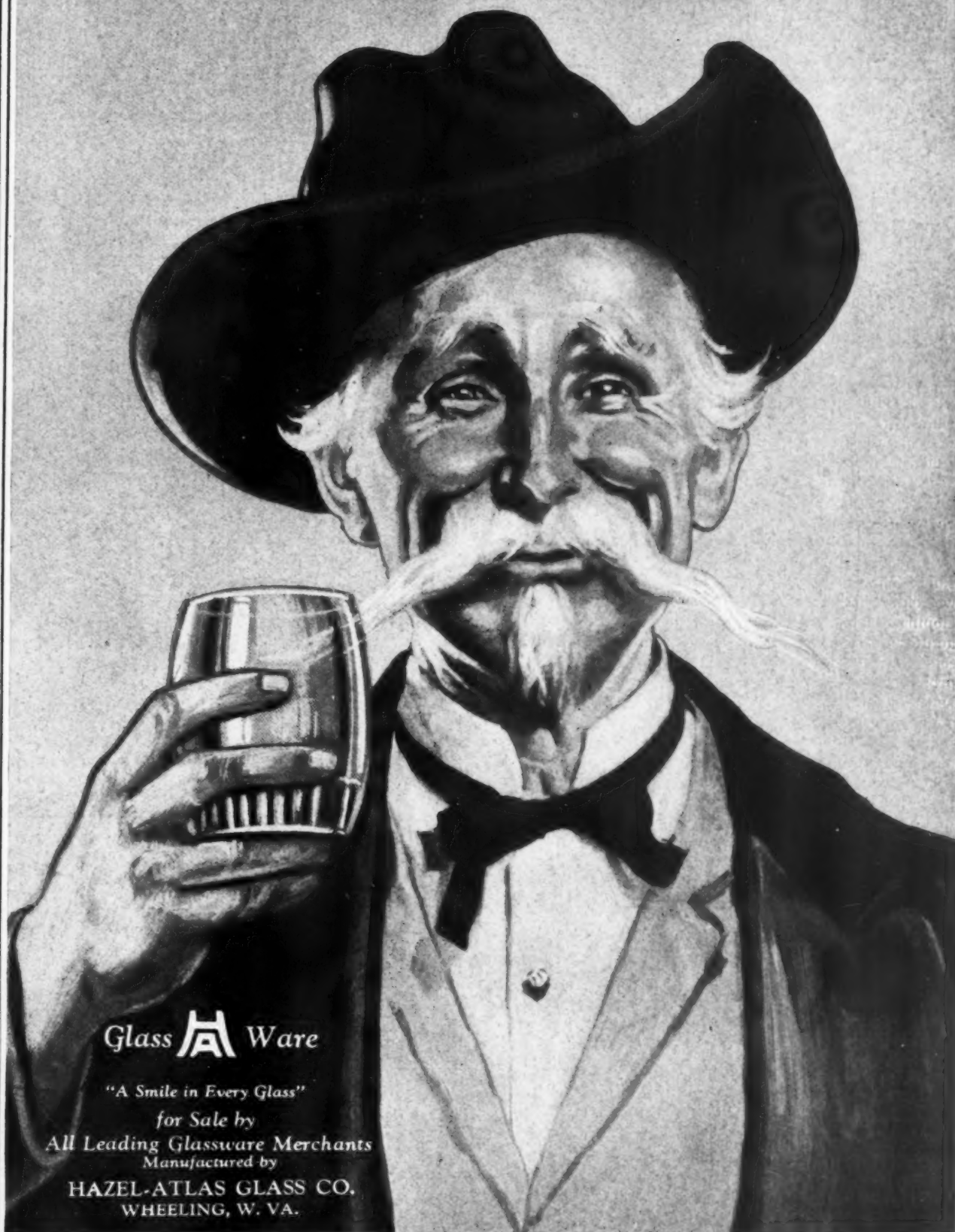
THE HOSPITAL DIETARY—AN EXAMPLE OF RIGHT LIVING

The principles of public health have begun to loom larger and larger on the horizon of medical interest. They are no longer merely the concern of health officers or other special government officials; they must be dealt with in the everyday practice of the physician. The medical student of today is confronted not merely with the duty of ministering to the sick, but also the application of preventive medicine—of prophylaxis in its broadest sense. More and more is this aspect of training for the prospective practitioner being introduced into the curriculum of the schools that prepare him for his life work. The gospel of correct living, so far as man's bodily welfare is concerned, is destined to become an important theme for all medically trained persons; they must warn their followers against the potential menaces of the ordinary regimen and exhort them to choose the paths of hygienic rectitude. An equally urgent duty confronts the modern hospital, which has to provide for many on its staff who are not ill and for not a few patients whose ailments or injuries do not involve their nutritive welfare in any direct way. From this standpoint, Fitz and Lautz of the Peter Bent Brigham Hospital, Boston, writing for the newly established *Journal of the American Dietetic Association*, remark that in constructing normal diets, hospital dietitians must recognize common present-day dietetic errors and habits and must remember that hospitals are becoming more and more centers of public health instruction for well and for sick persons.

Dietetic Errors

The most universal dietetic error, they believe, is the use of rich and concentrated foods in large quantities and irregularly. Such dietetic errors may result, at least, in obesity and chronic constipation. The public must be made to realize the possible dangers of obesity. Hospitals must set an example to their patients and personnel by serving model normal diets which are inexpensive, easily prepared, palatable and well-cooked, which contain sufficient bulk, calories and protein to cover the ordinary metabolic and digestive needs, and which are so balanced in their food components as to be sound in theory and practical usefulness. Another modern feature of institutional life consists in the prevention of "physical indolence" in the presence of current customs. As Haven Emerson has expressed it, if we would continue our appetites we must not abandon all exertion simply because opportunity of means and mechanical contrivance puts it in our power to do so.—*Journal of the American Medical Association*, November 28, 1925.

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and by ALEC N. THOMSON, M.D., Medical Secretary, Committee on Dispensary Development, United Hospital Fund of New York 15 W. 43rd Street, New York

A PEDIATRIC CLINIC AS A PROFESSIONAL AND COMMUNITY SERVICE

By I. Harrison Tumpeer, S.M., M.D., Director, Department of Pediatrics, Michael Reese Dispensary, Chicago

MICHAEL REESE Dispensary was established as one of the agencies of the Jewish Charities in the section of Chicago where most of the Jewish immigrants settled. During the early years of its history it played the emergency rôle of physician to those in need of immediate relief. Today its function is based on the broader hypothesis that social ills are founded on physical ills and that physical handicaps must be removed to correct social impairments.

The greatest hope for the promotion of physical health which we believe necessary for social health lies in maintaining and promoting the health of the child, and the most important factor in this endeavor is that of prevention. Therefore, our pediatric department must have a two-fold function: First, the correction of existing or developing defects, the patchwork type of work necessary in adult clinics, and, second, the prevention of physical defects that may cause social impairment, a program of prophylaxis. Stress is laid on the juvenile group because the defects of adult life are more or less permanent, and many of these originate in childhood. Inasmuch as this dispensary deals with a particular group of individuals and families who are known, for the most part, to other agencies of the charities, close cooperation is possible between physical and other forces involved in social improvement.

Departments Related to Those of Hospital

The various departments of the dispensary are related directly to the corresponding departments of the hospital. The services of the hospital organization consist of an attending physician, an associate and an adjunct. There are three such pediatric services. The six clinical days at the dispensary are divided into three groups of two days each, Monday-Thursday, Tuesday-Friday, and Wednesday-Saturday, over each of which an adjunct presides who acts as chief-of-clinic. He has full charge of his group, acts as consultant and passes on all cases referred to the hospital. It is his duty to review the records at the close of the session and to indicate suggestions for improvement of the records as well as the medical management. The associate attends one session a week, usually conducting a special clinic. In addition, there are from one to four physicians in each clinic who are not members of the hospital staff but are attached to the dispensary. Formerly, there was a half-time paid

worker who attended every morning, acted as general assistant, and made home calls on patients too sick to be brought to the clinic.

The other members of the clinical group are a nurse, social worker, laboratory technician and volunteer.

There are three sets of clinics holding sessions two days a week as described, which treat general pediatrics and a group of special clinics. These may be outlined as follows:

Pediatric

Cardiac
Albuminuria
Examining
Thyroid

Cooperative

Protein sensitization with medicine
Serology with dermatology
Mental hygiene with neurology
Eneuresis with neurology, urology and surgery

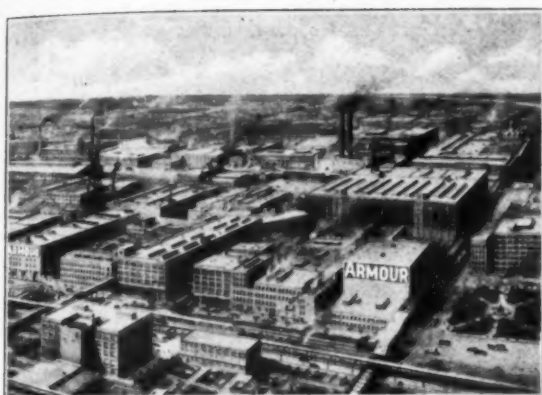
Special Agencies

Infant welfare by infant welfare society
Tuberculosis by Chicago Winfield Sanitarium
Vaginitis by gynecology department

Lay Cooperation

Nutrition with dietitian
Health classes with social worker and volunteer

The clinics designated as pediatric are manned entirely by the pediatric department. The examining clinic was organized for special use of the Jewish Home Finding Society. Its work is largely preventive. The children are given thorough physical examinations including eye, ear, nose and throat by the special departments. Cultures are made to protect the foster family from the possibility of a diphtheria carrier. In addition, vaginal smears are taken and Von Pirquet, Schick, Wassermann tests and vaccination are carried out. The Dick test has not as yet been introduced. In this routine manner several cases of albuminuria, vaginitis, syphilis, tuberculosis as well as the usual physical defects which would otherwise have escaped detection have been uncovered. The children are under control of the Jewish Home Finding Society, and the clinic serves as a good example of what can be accomplished under intensive methods of prevention.



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The cooperative clinics are conducted jointly with representatives of the departments named. This type of management combines the resources of the several departments and brings to bear more intelligent handling of the problems relating to the special fields. Protein sensitization was originally a pediatric clinic, but is now termed cooperative since one of its workers was appointed to the medical department of the hospital. Serology is so labeled to avoid the stigma attaching to the word syphilis which might be bandied about unconcernedly in the routine handling of patients by numerous clerks and workers to the embarrassment of the patient. Its problem is as much dermatological as it is pediatric. It was organized to carry out effective treatment of syphilitic children many of whom formerly drifted along on a desultory program of mouth medication. Furthermore, it provided a place where a survey might be carried out of the incidence of contamination of children associated with adult syphilitics. Children contacts of adult syphilitics under observation in other clinics are investigated by the serology clinic as part of the management of the disease in the adult and the community. In this way the family as a whole is considered as the unit of syphilitic infection and not the individual with active manifestations. This type of management is more thorough than is ordinarily possible in private practice. Mental hygiene is essentially a neurological or psychiatric problem. In an attempt to correlate behavior and physical manifestations the assistance of the pediatric department is sought for the physical inventory. Eneuresis is studied by several departments to correlate the interpretation of pediatrics with those of neurology from the physical and psychic standpoints, urology from the standpoint of local pathology and surgery from the present interest in the role of occult spina bifida.

Certain clinics are conducted by special agencies. In two of this group the clinic was first organized and conducted by the pediatric department itself and later delegated to the agency especially interested in that field. The Infant Welfare Society combined its local clinic with that of the dispensary. The tuberculosis clinic was transferred to the out-patient clinic of the Chicago Winfield Sanitarium, another agency of the charities, conducted in the dispensary building. This saved a step in transferring patients to the sanitarium proper, inasmuch as they had to be examined by the sanitarium's clinic before admittance. The vaginitis clinic was always conducted by the gynecology and urology departments but is limited to children.

The Nutrition Clinic

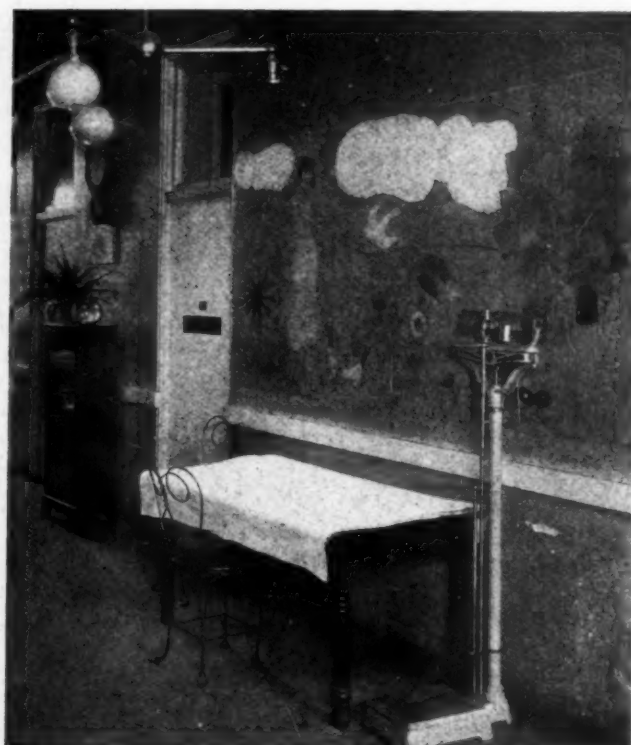
Some of the activities of the department are carried on by lay cooperation. The nutrition clinic is conducted by the dietitian. Children are referred to that clinic by the various pediatric clinics, and in turn the dietitian refers for correction conditions which arise in the group and for further medical study those children who do not show a gain. It has not proved practicable to assign a physician to this group. The problem of the underweight child should be studied from the standpoints of physician, dietitian and, not least, of the social worker, particularly with training in behavior problems. Health classes have been conducted by the social worker with the assistance of nurses and volunteer workers. Physicians are assigned to the meetings to discuss the medical aspects of hygiene in terms intelligible to children. Thereafter the nurse is better able to impress the children because of her position of liaison officer between the professional and lay viewpoints. The subjects so treated are

matters of personal hygiene, diet, rest, fresh air, cleanliness, clothes, posture and personal conduct. A class in adolescence is included. One year the Jolly Jester was employed to present his Punch and Judy performance illustrating the health lessons offered in a more didactic manner during the year. The enthusiasm and interest that has been shown in this type of health work cannot be overstated.

The clinic rooms (Figs. 1 and 2) are arranged and furnished with an attempt at wall decoration that will appeal to the child. In the bare examining room are reliefs in the form of flower pots, curtains and wall posters illustrating health lessons. The patient is prepared in an anteroom and is returned there after his examination. The waiting room is supplied with books to which there is free access. The danger of contagion is slight because the nurse is able to detect obvious symptoms. Furthermore, it is rare for a child with contagious disease to be brought to the dispensary, and if he were he would probably be too sick to be interested in books. Children with suspected contagious disease are sent in first to be examined by the physician to avoid the possibility of spreading the infection.

Juvenile Scenes on Walls

The walls are covered with pictures of trees and animals which appear grotesque to adults, but which were chosen by children of the dispensary age in a contest to determine those decorations most pleasing to them. The views appear somewhat impressionistic, but are the types that the children, themselves, might draw. It is a question of purpose. If the child is to be entertained during his wait such material should be chosen. If the idea is to instruct him while he waits the more orthodox mural decorations should be selected. Music, educational talks and more posters are to be tried in the near future to make the wait of the patient and his parent profitable to them. At present there is being conducted an interesting



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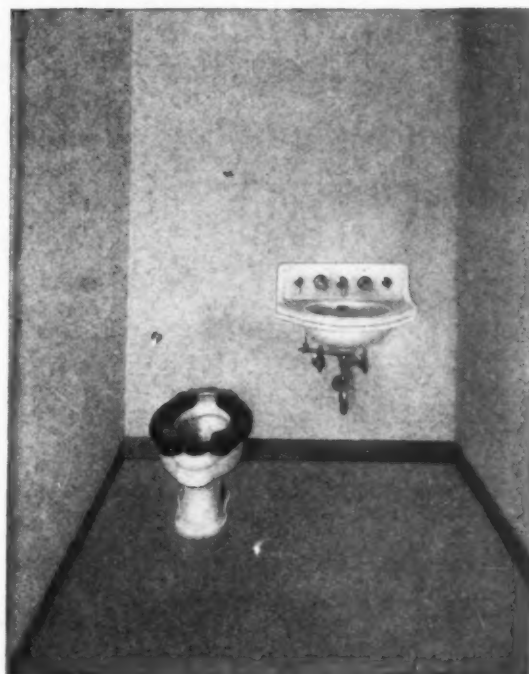


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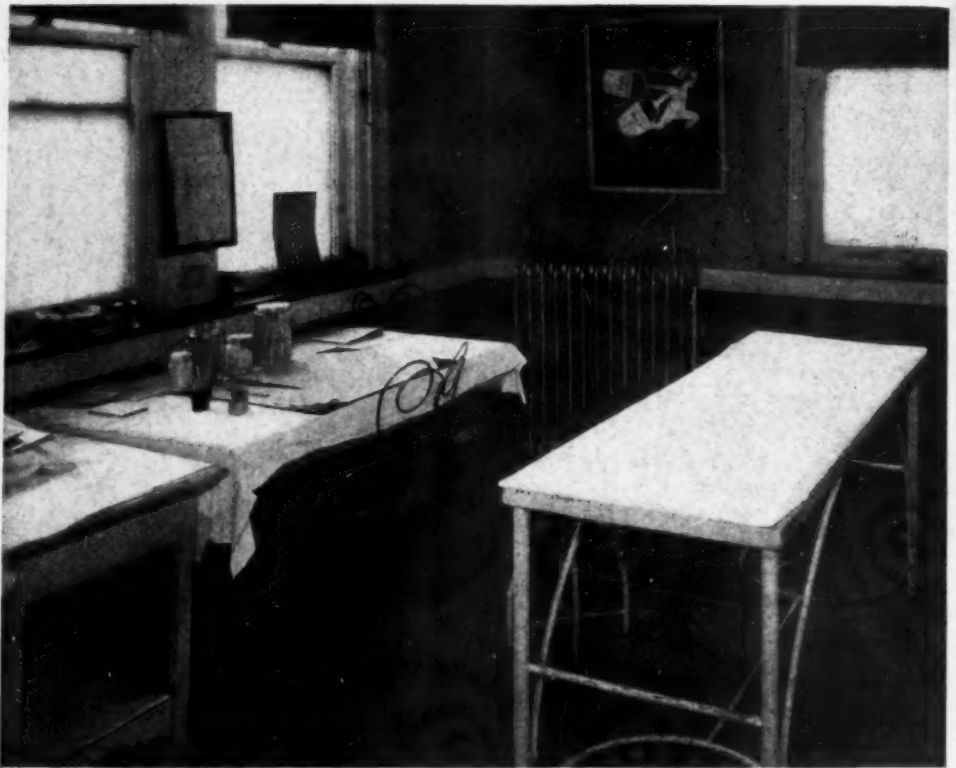
time study which is determining the length of time spent by a given patient in the various steps from admittance to exit from the building.

The clinics are conducted in the morning from nine until twelve. Patients may arrive from nine until eleven, and the physicians arrive at ten. The appointment system has not as yet been considered practicable except in the mental hygiene clinic. The patients are encouraged to come early so that there will be no waiting for examination by the time the records are sent up from the admittance department and the temperatures and weights are recorded. The rule of time holds true for all but emergencies. These are taken up at any time by the fellows of any department who act as house physicians. New patients have urinalyses. For blood examinations and Wassermann tests appointments are made with the laboratory.

In the larger quarters to which the pediatric department will move provision will be made for the physician, himself, to perform ordinary laboratory procedures such as he carries out in his office. Certain printed forms are at hand principally covering matters of diet arranged in lists from six to nine months, nine to twelve months, twelve to eighteen months, eighteen months to two and one-half years and two and one-half years to six years. Although there is much to be said for printed forms, the mechanical handing out of stereotyped forms lacks the personal touch of a written or verbal explanation on the part of the physician.

The record sheets, which have been standardized to a certain extent, contain a skeleton form for history and progress. This compels the examiner to determine and indicate an irreducible minimum of data. Latitude is permitted for individual variations depending on the indications of the case to be treated. This permits the skill, intelligence and experience of the physician free play. Minute details in history and physical examination of a routine nature are not practicable in a large clinic. Such detailed and standardized forms are useful where the data collected is to be used for statistical purposes at a later date and a uniformity of elicited facts is necessary to obviate the varying personal equation.

Physical findings, as the form indicates, permit systematic detail or the significant positive and negative findings from a differential standpoint, as the physician may decide. The physician's signature is sought so that the patient, upon return, may be referred to the same physician to prevent the former custom of the patient "shopping" about for an opinion which suits him. There is space for laboratory requests and findings for record and information so that the reviewer may see whether the proper approach has been made to diagnosis and treatment. Treatment is stated in detail for record. Diagnosis is stated last because it compels a summing



The severity of the ordinary examining room is here relieved by pictures.

up of the case in the examiner's mind and permits proper filing.

Where no conclusion is reached the fact is stated by an expression such as "diagnosis deferred," but some cognizance of diagnosis must be taken. Return date is indicated because follow-up depends on this information. A post card notification is prepared as soon as the record returns to the record room and is placed for mailing at a date which will bring the notification in time to remind the patient. The card states that the physician wishes to see the patient on the date indicated. On subsequent visits other data are sought that must be stated in the margin. These include the physician's name, date of visit, diagnosis and return date. In the body of the record is incorporated the data concerning progress, further history, findings, laboratory requests and treatment.

Until recently all new records were examined monthly by the director. This procedure was selected as a means of improving the work of the clinic as a whole in addition to the supervision of the particular clinic by the chief-of-clinic that day. It is impracticable for any one physician to make specific corrections or suggestions concerning the contents of clinical records to the individual physician. However, an index of the care and thoroughness in preparation may be found in the care of the physical aspects of the record forms. The purpose is not directly to censure the medical aspects but to determine the conscientiousness of the work itself. The record form gives such an index. Six points are sought in all records: Physician's signature, history, physical examination, treatment, diagnosis and return date. The importance and role of these points have been described. Absence of an item counts one error and misplacement one-half.

The total number of items is obtained by multiplying the number of records by six. The ratio of the number

RESTORING THE SICK TO HEALTH

AND

KEEPING WELL PEOPLE WELL

This double function—*keeping well people well and restoring the sick to health*—is one of the reasons why the hospital idea has been so universally accepted by the American people.

Restoring the sick to health, while originally the only function of the hospital, is more and more being supplemented by the service of *keeping well people well*, and all over the country hospitals are taking active leadership in health educational work.

Quite properly the service of any hospital includes educational work with resident patients, out-patients, and through its community contacts—educational work to the end of preventing those abuses of right living which lead to ill-balanced metabolism which so frequently shows itself through a diminished alkalinity of the blood and tissues due to an excess of acid products—*acidosis*. This excess acid is frequently observed for the first time when the patient enters the hospital or dispensary for diagnosis. It is the beneficent service of the hospital staff to go beneath the surface of things and find out the underlying causes.

Whatever may be the remote cause of hyperacidity, the simple corrective measures here discussed should be considered by those re-

sponsible for the diagnosis, treatment and care of patients in hospitals and similar institutions. Also a note of warning may well be sounded to those who are well so that they may conserve health.

Gastric hyperacidity, acidity of the mouth and other of the more obvious manifestations of acidosis are promptly counteracted by Phillips' Milk of Magnesia which has a pronounced affinity for acids, the harmless resultant compounds being readily excreted.

The increasing use of sodium bicarbonate by the public to control "acid stomach" should be considered in this connection. Only a part of the bicarbonate is effective and that portion which produces carbon dioxide may be seriously detrimental.

Phillips' Milk of Magnesia being free from carbonates does not distend the stomach nor cause flatulence of the lower intestinal tract. Its antacid action is pronounced. A given quantity of Phillips' Milk of Magnesia neutralizes almost three times as much acid as a saturated solution of sodium bicarbonate and nearly fifty times as much as lime water. Further it has the additional merit of being laxative, a quality of importance here since constipation is so frequently the underlying cause of hyperacidity.

DOSAGE—The usual dose of Phillips' Milk of Magnesia, as an antacid, ranges from one teaspoonful (4 c. c.) to one tablespoonful (16 c. c.). This amount should be mixed with an equal portion of cold water or milk and given half an hour after meals.

For its laxative effect, the adult dose is one to two fluid ounces (30 to 60 c. c.). The aperient action may be facilitated by giving the juice of lemon, lime or orange, half an hour thereafter.

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of errors to the total number of points may then be expressed in percentage terms. Objection may be made to this mechanical type of judging. But a percentage demonstration of irregularities and inaccuracies in work is a graphic representation to the workers which impresses them with the necessity of care in the clinic. Furthermore, in this scheme of marking there can be slight opportunity for variation or unmeasurable error in marking due to the personality of the reviewer.

Two-Day Clinic Examined as a Unit

At first, the entire clinic group was so marked. Later the two-day clinic was examined as a unit inasmuch as these groups were presided over by a single person and still later each day was studied since the personnel of the individual days varied. No attempt was made to represent the errors of the individual. This was readily evident in the usual review, because the same individuals were responsible for the same proportion of errors quite constantly. These individuals, too, were usually the least desirable from the professional standpoint. After the markings had been stabilized more attention was paid to substance. This does not lend itself readily to accurate measuring and graphic representation. Instead, the new records were scrutinized from the standpoint of a satisfactory clinical record in addition to their usual markings. When it appeared that some fact was omitted which might be pertinent in the mind of the reviewer, who saw the chart as an accurate clinical record, a suggestion was made on the chart and the patient's record marked for return to the clinic so that the point might be taken up by the physician when he next examined the patient. For instance, a patient with epilepsy is returned so that a Wassermann test be made and further data elicited in the history concerning other periodic manifestations such as cyclic vomiting and migraine. A patient with asthma is returned with the suggestion that protein sensitization tests be carried out either by the examining physician or by the special clinic to which such cases should be sent if the general clinic wishes to study the case no further. A patient with cardiac disease is brought to the attention of the physician with like suggestions to study the case further or at any rate to refer it to the special clinic. In a case of high fever with pharyngitis suggestion is made to indicate the examiner's exclusion of otitis media or pyelitis. In this manner definite conclusions, in so far as these are possible, are arrived at, and the patient is accorded thorough management or follow-up.

Too often these unfinished or incompletely worked up cases become the socially impaired. In reviewing histories of cardiac, nervous and chronic respiratory cases a long fragmented account is found extending over years without any summing up at any time. From the standpoint of good medical work alone these records are written accusations. After acute infections, if the request is not noted, the patient is asked to return to the examining physician to determine whether there have been the cardiac or respiratory complications which so frequently follow insidiously and remain unnoticed until a grave situation intervenes. In the ambulatory clinic it is especially important to study and search for the insidious, indefinite foreboding beginnings of chronic disease which Mackenzie has accomplished so much to bring forth from obscurity. Latterly, it has been assigned to the chief-of-clinic to review the records inasmuch as he is in closer contact with the physician and the cases are better remembered when they are discussed on the date of examination.

In a department of twenty-five members, prescribing

is a troublesome and complicated problem. In a dispensary where pediatrics forms merely one of the many departments represented in the field of medicine the problem becomes still greater. The Michael Reese Dispensary is very liberal in supplying any drugs which the patient may require. There is practically no censorship. In a review of the records of the dispensary the variety of drugs and preparations prescribed was striking, although their pharmacological differences were slight. It seemed that the number of drugs might be reduced if consideration were taken of these slight pharmacological differences, the large expenditure of time in filling, and the matter of cost.

A study was made of the prescriptions written in the pediatric department for a period of ten days. The conditions for which the preparations were used, the most commonly used drugs and a list of all drugs employed were tabulated. It was evident that the whole matter of prescribing could be simplified without prejudicing the best interests of the patient. It was found on analysis that 70 per cent of internal medications were written for three types of medicine, namely, cough, fever and tonic. Twenty different drugs were used for cough and nineteen for fever. After consultation with pediatric and therapeutic authorities this list was reduced to four or five drugs. The palatability of mixtures was next investigated and the most palatable mixtures prepared. It was also found that prescriptions were written for lavish quantities. There was no reason for prescribing four ounces of medicine to a patient who was to be seen again in a few days and might no longer require medication.

Study of Prescription Ingredients

A study of the ingredients in some of the mixtures and the number of handlings necessary for their preparation indicated that the effort in filling them was far out of proportion to the advantage therefrom. Stock prescriptions were prepared according to the most useful combinations. It was strongly suggested that physicians prescribe these mixtures or other simple mixtures, where practicable, obviating the multiplicity of ingredients that were formerly ordered indiscriminately. Conditions were reviewed two months after the suggested reforms with good results as far as the department and the pharmacy were concerned. Although no further attention was called to the advisability of prescribing simple mixtures, another study two years later still showed the benefit of the reforms suggested.

Objection may be made to stock prescriptions. The formulae are posted in each clinic room so that the physician knows at all times what he is ordering. From the therapeutic standpoint there can be little objection because the important ingredients have been included for their therapeutic importance. Furthermore, the stock prescriptions may be altered without unduly complicating the handling. The inconsequential energy involved in the literary composition of a prescription by the physician and the meticulous assembly of five or six ingredients on the part of the pharmacist is now saved by a brief order with a quick filling of the order by the pharmacist and a consequent saving in time to the physician in writing his records, the pharmacist in filling and the patient in waiting.

Patients are referred to other departments or special clinics and transferred for consultation or treatment. They are transferred when it is entirely a matter for the special clinic to manage. A pediatric department organized with many special clinics has a tendency to become so finely subdivided that the general clinic acts

DRIVE

WHAT an obnoxious term, this word "Drive!" What unpleasant thoughts it raises of dragooning people onto committees, of getting men into corners and telling them what they *must* give! Why exalt brute force? Why crystallize and emphasize public resistance? Well-organized, carefully-conducted *campaigns* of public education, based on modern selling principles, are replacing "Drive" methods.

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merely as a clearing-house for so-called interesting cases that are sent to other departments or clinics. The function and the duty of the dispensary toward the physician must be taken into account. Men work in clinics for professional advancement. Therefore, the department owes its members the privilege of full development of their clinical opportunities. It is the attitude of the department that the general as well as the special clinics be encouraged to work up their cases to the utmost so that they may obtain the full value from their cases. On the other hand, the physician in the special clinic should have access to all cases which bear on his particular study. To harmonize the general and the special clinical interests it is arranged that a case may be referred to a special clinic with a return request so that the general clinic may obtain the additional data of the special clinic and profit by more intensive study. If the general clinic wishes, it may transfer the patient, indicating that the case is completed as far as the general clinic is concerned and that it is transferred for the benefit of the data and research which the special clinic desires. It is our experience that this attitude is more stimulating to all members. On the one hand, the general clinic cannot lament the removal of its most interesting cases to the special clinics. On the other hand, the special clinic cannot complain that more of their cases are to be found in the general clinic than in their own. The social worker is the intermediary through which arrangements are made for referring, transferring and returning. To further advance the interests of the attending physician, rotating services have been instituted so that the men of the general clinic may participate in the special clinics.

One Month's Postgraduate Course

During the course of the year a one month's postgraduate course in pediatrics is offered by the hospital. Two days of the week are arranged at the dispensary where ambulatory conditions are demonstrated. These are more closely related to practical medicine than hospital material. These subjects include vaginitis, tuberculosis suspects, protein sensitization, dermatology, mental hygiene, neurology and general pediatrics. Applications are constantly coming in from physicians who wish to work in pediatrics merely for experience. This type of postgraduate activity is as important to the community as the more formal methods of teaching. As nearly as possible the newcomers are assigned to the chief-of-clinic for direction. Rotation of these men among the various special clinics has increased the professional value of the dispensary clinic to the attending physicians. The interns at the hospital receive one month's training at the dispensary where from their admissions they obtain more practical information than they are able to receive at the hospital inasmuch as the hospital is concerned with the end-results of out-patient cases.

Encouraging Research

Research is encouraged. Several reports have been published, and more are being prepared. Most of these are of the clinical type, although the laboratory cooperates in some of the work. All features such as the laboratory and the x-ray department of the dispensary are at the disposal of the physician for research work. The special clinics, particularly, are adopted for research.

In the endeavor to maintain the highest ideals of the clinic, staff meetings are held of the entire staff of the pediatrics department and members of participating departments, especially in the special clinical field, nurses, social workers, laboratory technicians and volunteers. When

these meetings are interrupted for any period of time, interest in the department lags. For a period, interesting or puzzling cases were referred from the dispensary to these meetings.

CLINIC EFFECTIVE IN FIGHT AGAINST VENEREAL DISEASE

The Illinois Social Hygiene Clinics, according to their recent annual report, have treated 10,000 men and women during the last five years. These people were employed by over one thousand concerns in Cook County. Virtually every form of business, including chain restaurants, exclusive hotels, desirable clubs, large industrial corporations, barber shops and bakeries had employed them and, but for the clinics, they would have remained public menaces and might easily soon have become public charges. Fifty per cent of the men and seventy per cent of the women paid nothing and no one able to pay doctors' fees was accepted. The clinics, however, not only received them but were, in most cases, able to hold them until cured.

During 1924 alone, over three thousand men, women, and children were given over 20,485 treatments and thus rendered non-infectious and safe to mingle with fellow-employees and others. Two thousand and twenty-three of these patients were new to the clinic. Of this number 1,535 cases were diagnosed as positive, 1,284 men and 251 women. One thousand one hundred and one had had no previous treatment.

Only a fourth as many of the new cases were women as were men, yet there were twice as many women infected by husbands as men by wives.

A markedly large proportion of the patients treated—over half of the cases considered—were American-born. The report emphasized, however, that this did not show a tendency on the part of native-born Americans to contract venereal diseases but was due to the fact that the educational work of the league had not yet reached the foreign-born group.

SCALE HELPS DIABETIC PATIENTS

A diabetic clinic, realizing how difficult it is for the average person to judge the weight of food to the degree necessary in a strict diet, will loan to patients a scale which indicates the weight in grams. For a small deposit the patient is allowed to keep this as long as he needs it. On its return, his deposit is given back and the scale is passed on to a new patient.

DANGER!—SEE SOCIAL SERVICE

To make sure that the patient who should consult the social service department, reaches that department before he attends clinic, such patients are given a red card. These red cards indicate to clinic workers that something is wrong and that the patient must not go through the regular routine until adjustments have been made in the social service department.

The Wyckoff Heights Hospital, Brooklyn, has added four new clinics to its services. These are a children's clinic every Tuesday and Friday from 2 to 4 p.m.; a skin clinic, every Tuesday and Saturday from 2 to 4 p.m.; a diabetic (insulin) clinic every Monday, Wednesday and Friday from 2 to 4 p.m.; obstetrical and gynecological clinic every Tuesday and Friday from 2 to 4.



Architect, Alfred F. Priest
Los Angeles, Cal.

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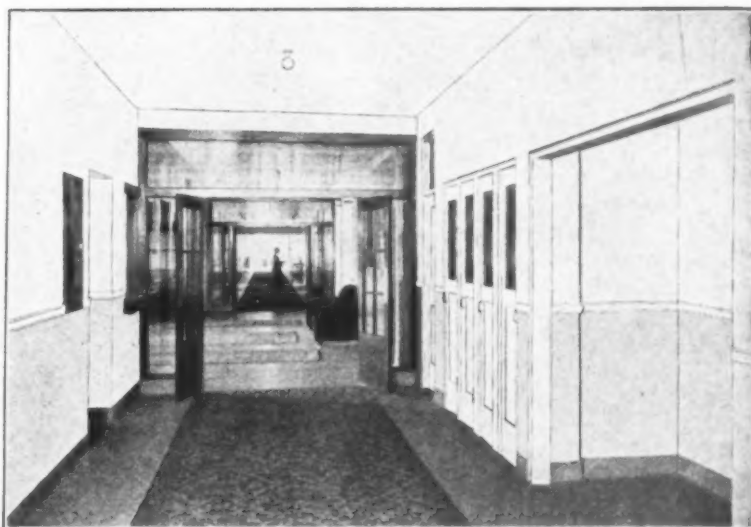
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MEETINGS, CONVENTIONS AND CONFERENCES

PROGRESSIVE IDEAS MARK MEETING OF MICHIGAN HOSPITAL ASSOCIATION

THE ninth annual meeting of the Michigan Hospital Association was held, December 10 and 11, at the Book-Cadillac Hotel, Detroit, with an attendance of more than fifty members from all parts of the state. The meeting was divided into three sessions, a luncheon and an inspection tour of the Henry Ford and Highland Park Hospitals and the Clara Ford Nurses' Home.

With only three sessions the interest of the members and guests was intensified and held until the final discussion of the last paper. Many new and progressive ideas were put forward both by the speakers and in the business sessions. All of the meetings were presided over by Dr. Stephen L. O'Brien, St. Mary's Hospital, Grand Rapids, with the exception of the round table which had as its conductor Dr. Warren L. Babcock, director, Grace Hospital, Detroit.

Vote Sum for Book on Hospital Laws

The association after hearing the report of Father M. P. Burke, Ann Arbor, on the feasibility of publishing in book form the state and national laws applicable to hospitals in Michigan, voted \$1,000 for this purpose, and a committee will be appointed to see that this work is carried forward. The idea was favorably received and it was pointed out by Father Burke that such a book, suitably bound, would be a valuable addition to the hospital's library. Abstracts of recent decisions in federal and state courts—particularly Michigan—full explanation of the Harrison law, the withdrawal of liquor procedures and other pertinent regulations will be embodied in the book.

Dr. W. L. Quennell, superintendent, Highland Park General Hospital, Detroit, who has been the first vice-president of the association, was elected president succeeding Dr. O'Brien. The officers elected were: Dr. H. A. Haynes, medical director, University Hospital, Ann Arbor, first vice-president; C. D. Letts, superintendent, Memorial Hospital, Owosso, and Margaret A. Rogers, superintendent, Children's Hospital of Michigan, Detroit, second vice-presidents; Dr. D. M. Morrill, Blodgett Memorial Hospital, Grand Rapids, secretary; Amy Beers, Hackley Hospital, Muskegon, treasurer, and Dr. Warren L. Babcock, Grace Hospital, Detroit, and S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, trustees.

The meeting opened with an address of welcome delivered by Mayor John W. Smith of Detroit, who was introduced by President O'Brien.

The first paper presented was by Dr. Pliny F. Morse, director of laboratories, Grace Hospital, Detroit. In a comprehensive manner Dr. Morse told not only of the activities of the laboratory, but how the work should be coordinated with that of every other department. He stated that all interns should be given training in laboratory work and should learn the value of pathology in the general practice of medicine and surgery. Dr. Morse's paper was specifically discussed by Dr. C. L. Owen, director of laboratories, Harper Hospital, Detroit, and generally discussed by many of those present.

Following the luncheon, at which Dr. Babcock presided, Dr. Haynes explained the relation of the University Hospital at Ann Arbor, to the other hospitals of the state. He briefly outlined the new project and told how it was going to work out for the benefit of the other institutions.

Hospital Charges Discussed

S. G. Davidson, Butterworth Hospital, Grand Rapids, presented the next paper which took the form of a rather thorough discussion of the corporation charges by hospitals, and the necessity of getting together for some kind of a fixed rate whereby hospitals would be allowed at least the bare expenses of keeping hospitalized employees of industries, whether they were sent by the compensation board or by the industry direct. It was of interest to note that a wide difference in charges exists at the present time in the state of Michigan. At Flint the charge to corporations is \$3 a day, plus charges for extras; at Lansing the charge is \$3.50 a day to factories and \$3 to the city, plus charges for extras; at Detroit the charge is \$4 a day, plus charges for extras and at Grand Rapids, where the hospitals have "got together," the charge is \$4.50, plus charges for extras.

Dr. Warren L. Babcock's round table was a feature of the meeting. There were only about fifteen questions, but every one was worth while and of vital importance to hospital executives. Interest was sustained throughout the entire list and much valuable discussion was evoked.

Eleanor E. Hamilton, R.N., superintendent, Edward W. Sparrow Hospital, Lansing, read the last paper of the first day's session which pertained to group nursing in general hospitals. She told of the success that she had experienced with group nursing in her own hospital and said that the patients were better satisfied with this method than with other methods that has proved to be more expensive.

On Friday morning Dr. A. E. Schiller, chief of the de-

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"We have used the small household type of vacuum cleaner, but it will not clean with anywhere near the thoroughness of the Invincible. When our new 7-story addition was planned, we considered installing a stationary cleaning system; but the much lower initial cost and general satisfaction of the Invincible caused us to decide upon it.

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partment of physiotherapy, Grace Hospital, Detroit, read a paper on "Physiotherapy in General Hospital Practice" and this was discussed by Dr. R. V. Funston of the outpatient department, Harper Hospital, Detroit, and Dr. Charles E. Stewart, Battle Creek Sanitarium, Battle Creek. Dr. Schiller's paper will appear in a later issue of *THE MODERN HOSPITAL*.

Carrie L. Eggert, R.N., superintendent, Woman's Hospital, Detroit, read the next paper on the subject of breast milk distribution. Following her paper a reprint of a paper by Dr. N. Raymond Hoobler, entitled, "Human Milk," read before the American Pediatric Society, Pittsfield, Mass., June 5, 1924, was distributed.

Maud McClaskie, R.N., and Helen B. North, R.N., of the Farrand Training School for Nurses, Harper Hospital, Detroit, gave a demonstration of nursing technique in special procedures. A dressing car was shown with the various instruments in place, and a mimeographed list of the contents of the car was distributed.

Luncheon was enjoyed at the Henry Ford Hospital and a visit was made to the Highland Park General Hospital.

Among the business transactions was also the appointment of a committee to consider the advisability of changes in the by-laws of the association so that the first vice-president would automatically become the president each year.

HOSPITAL ECONOMICS MAIN TOPIC OF DISCUSSION AT CONNECTICUT MEETING

HOSPITAL economics, the price which Connecticut hospitals are paying for their milk, and the relation of organization to costs were the principal subjects discussed at the annual meeting of the Connecticut Hospital Association, held at the Waterbury Hospital, Waterbury, December 5, 1925.

The morning session was devoted to the routine business of the organization, after which there was a round table discussion. Charles Lee, superintendent, Waterbury Hospital, brought out the interesting fact that by purchasing coal directly from the mine in carload lots, his hospital was able to save about \$500 a month. The Waterbury Hospital has a coal storage capacity of 200 tons. The hospital has had an occasional, but never a serious, fire in its bunkers.

The question of laboratory charges was also discussed at some length, a show of hands indicating that some of the hospitals charged a flat laboratory fee, but a greater number charged for the laboratory work actually done.

Following the round table discussion, C. D. Hough, general manager, Connecticut Milk Producers Association, discussed the question of the price of milk paid by hospitals in Connecticut. His discussion was based on the answers to a questionnaire sent to the various hospitals in the state. The questionnaire showed that in general the retailers were not overcharging hospitals for milk. He warned hospitals against purchasing milk on the mere statement that it was state inspected, since all herds in the state are thus inspected, and urged that pasteurized milk be used as a protection against tuberculosis. Mr. Hough expressed the opinion that milk pasteurized at 142° F. for thirty minutes does destroy tuberculin bacilli.

Following Mr. Hough's address, Dr. Harold W. Hersey, superintendent, Bridgeport Hospital, Bridgeport, read a paper on "Hospital Economics." He expressed regret at the fact that the accounting systems of the different hospitals were not more uniform, which fact makes it difficult to obtain figures that may be compared. Comparable figures for eight institutions were, however, submitted.

Dr. Hersey also submitted some interesting figures relative to the expenditures of the general hospitals in New York showing the following averages:

Forty-four and fifteen-hundredth per cent for salaries and wages; 21.15 per cent for food, ice and water; 6.825 per cent for fuel, light and power; 8.675 per cent for medical and surgical supplies; 4.575 per cent for household furniture and supplies; 4.1 per cent for ordinary repairs, and 10.525 per cent for other expenses.

He talked at length on the budget system indicating that the budget serves as a guide to the financial management of the institution. Consequently, a statement should be drawn up each month showing the amount of the budget for the month, the amount of expenditures for the month, and whether the institution is exceeding or living within its income. Since a great proportion of the expenditures of the hospital is for provisions.

Following the luncheon at the hospital, Joseph J. Weber, superintendent, Grace Hospital, New Haven spoke on "Hospital Organization in Relation to Hospital Costs." Mr. Weber pointed out that the physical plant of the hospital had much to do with the cost of running the institution and that there was a point beyond which effective organization could no longer cut down costs because of gross errors in the planning and construction of the hospital. He pointed out such errors in planning an inadequate space for given units, too widely scattered buildings, varying floor levels, unnecessary stairways, lack of or inadequate, elevator service. He laid emphasis on the two basic principles of organization in its relation to costs namely, the ultimate responsibility of the board of directors for the efficient and economical administration of the hospital, and the necessity of having the executive authority centralized in the superintendent. He pointed out that proper and economical care can be rendered only where there is the closest possible coordination to the various services, and that this can be accomplished only when the various departments of the hospital have a keen sense of their individual responsibility to some coordinating agent. He threw out a warning against any encroachment upon the executive function, either on the part of individual members of the board of directors or members of the woman's auxiliary. He emphasized the budget, both as a definition of services and as a control on expenditures, and urged superintendents to undertake the preparation of budgets of production as well as budgets of probable costs.

The constitution of the association was modified to provide for holding at least two meetings each year. The following officers were elected: President, Dr. E. T. Reeks, superintendent, New Britain Hospital, New Britain; first vice-president Edward M. Weber, Stamford Hospital, Stamford; second vice-president Sister Valencia, superintendent, St. Francis Hospital, Hartford; secretary, Evelyn M. Wilson, superintendent, Stamford Hospital, Stamford; and treasurer, Anna M. Griffin, superintendent, Danbury Hospital, Danbury.

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*... this amazing new substance that
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We shall be glad to send you samples of these new Cordleyware products free of charge—for, frankly, we know from experience that once you see one, you will want more at once. But you don't mind, do you, if you get something so much worth while in return? Cordley & Hayes, world's largest manufacturers of sanitary drinking devices, 26 Leonard Street, New York City, U. S. A.



This Cordleyware flower vase available in 12 sizes; colors, mahogany or foliage green; being a non-conductor of heat or cold, flowers stay fresh longer. Finish resembles bark of a tree—natural background for flowers.

The Cordleyware pail, ideal for handling water or other fluids, including acids, chemicals, also food products; cleans easily—taint and odor proof. It is noiseless, rustless and non-scratching—features of inestimable importance.



The new Cordleyware waste basket—noiseless rustless—waterproof—non-corrodible; colors, mahogany, foliage green or special color to order in 12 dozen lots—rustic or leather finish. 3 sizes.



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sanitary drinking devices,
New York City.



Cordleyware products also
include waste baskets, spit-
toons, pails, fire pails, etc.
Write for prices.

HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

Conducted by HERMAN SMITH, M.D., Superintendent
Michael Reese Hospital, Chicago, Ill.

PROTECTING THE HOT WATER PIPING SYSTEM AGAINST CORROSION

If a person is as old as his arteries it may be said with equal truth that a building is as old as its piping system.

Usually the first evidence the management of a building has that the building is growing old is the complaint about the hot water system. Complaints may originate from the laundry on account of the rusty water

attendant annoyance and expense of tearing out imbedded pipe, damage to walls and furniture, and the shutting off of the hot water until the repairs may be made.

When the piping system begins to fail call the plumber. Although he is able to replace pipe and stop leakage, he is not able to prevent future trouble, and eventually the management is confronted with the fact, that in order to keep the building a first-class institution, it is necessary to spend many thousands of dollars in completely repiping it.

There are three processes which may be employed to protect hot water piping systems against the ravages of corrosion. The first of these is known as the silicate of soda process, which consists of injecting into the pipe line this chemical in the form of an emulsion.

Silicate of soda, or water glass, is only slightly soluble in water, and will be precipitated in the pipe, forming a protective coating that will prevent the oxygen in the water from coming in contact with the walls of the pipe. It is mostly the free and dissolved oxygen that is the corroding agent in water, and if the coating will keep the oxygen from contact with the pipe, corrosion will be very materially limited in its action. The objection to this chemical process, however, is that nearly all the emulsified chemical will be precipitated out of the water in a run of pipe 150 feet in length.

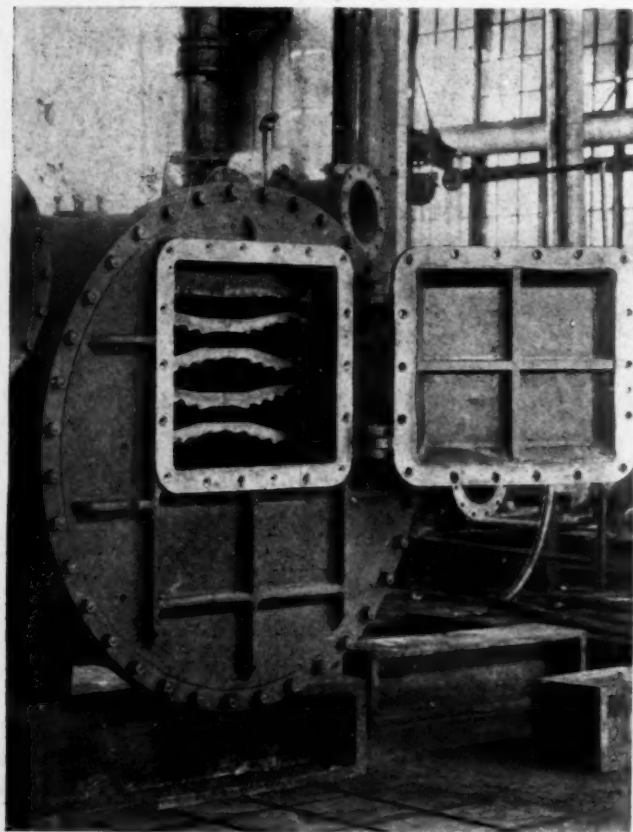
For very small buildings that do not require great quantities of water, this process is excellent, provided that sufficient injections of the chemical are made to offset its being dissolved from the pipe.

For larger buildings, however, it has little merit because the corrosion will be found in concentrated form in the piping, which is more than 150 feet away from the source of the silicate, or in the return piping system.

The other two processes of preventing corrosion are mechanical, and are known as the deactivating and the deaerating processes.

A deactivator is a large tank filled with steel lath. The hot water passing through the lath in the tank gives up all the corroding gases to rust the lath, and by the time it reaches the outlet of the tank all the oxygen has been absorbed by the cheap steel lath, and the water which goes into the system is practically gas-free.

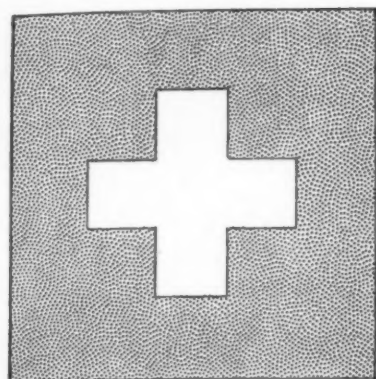
There are limitations to this system the same as there are to the silicate of soda process, as the tank required must be of sufficient size to provide an hour and a half's storage of the hot water. This time is necessary for all of the oxygen to be given up to the steel lath. Therefore,



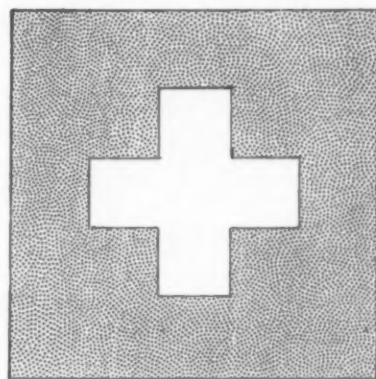
Equipment for deaerating water in large hospitals. The boiler has a capacity of 8,000 gallons per hour.

soiling the clothes, or perhaps the occupants of the top floors cannot draw hot water because of lack of pressure, resulting from the pipes being choked with the products of corrosion.

Then in a few years, when the corrosion has actually eaten through certain sections of the pipe there is the



Every Hospital
can now enjoy
the convenience
of Gas Service



IF YOU do not have city gas service, you will find Pyrofax a real convenience in the main kitchen, the diet kitchens and the laboratory.

Pyrofax is made from natural gas and is shipped to the consumer in steel cylinders. It is non-toxic and burns with a clean, hot flame free from soot or odor. It can be used on any standard gas appliance — ranges, hot plates, Bunsen burners, and laundry ironers.

The Pyrofax installation consists of a substantial enameled steel cabinet which houses the cylinders and fittings. It is placed on the outside of the building and the gas is piped from it through ordinary gas pipe to the stoves, burners and other appliances. It is listed as standard by the National Board of Fire Underwriters.

Any further details will be promptly furnished on request. May we not send you our circular and booklet describing Pyrofax?

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Its simple form is easily handled by the most delicate digestion

Physicians know that food values are only half the story when it comes to nourishment. The other half is equally important—digestibility.

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Because Cream of Wheat fills requirements not only of rich food values but of easy digestibility, in an exceptional way, it has had a standard place on diet lists for 30 years.

A wonderful energy food, high in carbohydrates—this is its first qualification. In addition, it is in a form which is so simple it can be handled easily by the most delicate digestion and readily assimilated.

Cream of Wheat offers another advantage which physicians are quick to appreciate—its uniform quality and full protection from all impurities.

After milling it is thoroughly heat-processed; then it is packaged in a tight box and triple-wrapped-and-sealed, proof against dirt and weevils. No other cereal food is so scrupulously guarded.

When you want a valuable carbohydrate food which infants and invalids can digest without tax, you can safely designate Cream of Wheat, sure that it is always the same, winter or summer, clean and untouched by contaminating dangers.



Cream of Wheat

Cream of Wheat Company, Minneapolis, Minnesota
In Canada, made by Cream of Wheat Company, Winnipeg

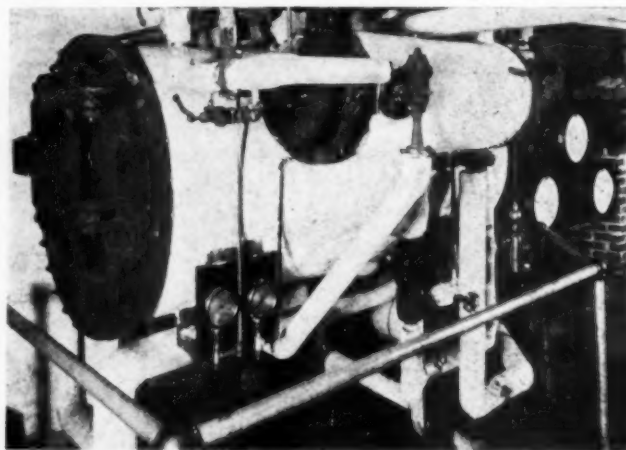
FOR 30 YEARS A STANDARD FOOD ON DIET LISTS
© 1925, C. of W. Co.

on account of its size and weight, it is not practical to build this apparatus in sizes larger than 1,000 gallons per hour capacity. This system is not particularly expensive. It can be purchased in combination with a heater, and, therefore, at not a very much greater outlay, a storage heater in combination with a deactivator can be purchased instead of the usual storage heater alone.

The apparatus, while requiring little, if any, supervision, must periodically be recharged in view of the fact that the steel lath will eventually rust to a point where it can no longer absorb oxygen. However, it usually requires two or three years before this recharging is necessary.

The third process, deaeration, is the most positive of any of the systems, because through it the oxygen and the other corroding gases are absolutely eliminated from the water. It is a well-known fact that boiling water will remove the dissolved gases contained in it, and this principle is employed by the deaerator.

Hot water from the heater is conducted to the deaerating



An installation of deactivating equipment suitable for medium sized hospitals.

chamber where it is flashed and sprayed over the pans in the chambers. The degree of vacuum maintained in the chamber has a boiling temperature lower than the temperature of the incoming water, and, therefore, the water, as it passes over the pans, violently boils, giving up its dissolved gases and some vapor. By means of an air pump, the gases and vapor are drawn through a condenser where all the heat contained in them is given up to the cold water on its way to the heater.

It will be noted that this system, neglecting radiation losses, is 100 per cent thermally efficient. The degree of vacuum maintained in the deaerating chamber is regulated by means of a valve, and this regulation is such that the occupants of the building are assured of obtaining water constantly at a definite, controlled temperature.

Deaerators are built in sizes ranging from 500 gallons per hour up to 25,000 gallons per hour. The smallest size unit occupies a floor space of six feet by four feet in the basement, while the largest size takes up a space of approximately fourteen feet by ten feet.

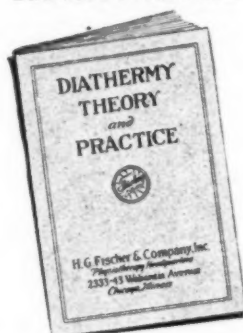
All the accessory parts of the deaerator are attached and piped to the deaerating chamber. Therefore, after it has been located in the basement, all that is necessary to connect it with the system is to bring to the apparatus the water inlet connection, pipe up the outlet connection to the pump which furnishes the hot water to the building, bring the steam connection for the heater, and take

The Experience of Others with Physiotherapy

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A Handbook You Need!

*Comprehensive—
Authoritative*



This book contains up-to-date information for practicing physicians, giving illustrations and typical case histories and discussing authoritatively diathermy in all its phases. It is offered for the first time to the profession at large. It is another of the products of the broad educational program that is being carried out by H. G. Fischer & Co. for the purpose of giving reliable information on this comparatively new science.



THE experiences with Physiotherapy of such representative institutions as the Battle Creek Sanitarium, Battle Creek, Mich., Barnes Hospital, St. Louis, St. Luke's Hospital, Chicago, the Lord Lister Hospital, Omaha, and many others are contained in this new portfolio, together with reports, floor plans, photos and memoranda. It is available to any superintendent, staff physician, consultant or architect planning a Physiotherapy Department.

It is loaned without charge or obligation by the Educational Department of this Company, whose purpose is to advance the science of Physiotherapy.

At your service, too, is the Fischer Technical Plan and Engineering Bureau which will lay out a floor plan to fit your available space and will indicate the equipment required and its proper location.

In common with all the Fischer Educational Service, these helps are supplied without fee and place you under no obligation. You will find them most useful and the advice given is wholly disinterested.

Correspondence is invited from interested physicians and hospital authorities.

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Physiotherapy Headquarters

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HENRICIS wash more pounds per dollar

MANY laundrymen are surprised to learn how greatly washing costs are reduced by using Henrici Washers.

Let us make a comparison. Many tests show that Henricis do the work of two, three, or more ordinary washers of the same size. A distinct economy in floor space, labor, power, and supervision.

Henricis make great savings in water, steam, soap, and supplies.

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Let us demonstrate by figures how Henrici Washers will give you *more pounds per dollar*.

HENRICI LAUNDRY MACHINERY CO., Boston 26, Mass.

HENRICI WASHERS

SPEEDY - ECONOMICAL - DURABLE

care of the small drain connection from the heater.

The application of deaerators to stop corrosion in hot water piping systems is the most positive means of prevention, and although deaeration is still a rather new proposition, in every case where the apparatus has been installed, it has absolutely prevented further corrosion.

Hospitals, where water is used in quantities, will find the installation of a deaerator desirable. It cuts down plumbers' bills, and puts off indefinitely the problem and expense of repiping.

INCREASING SPEED AND ACCURACY IN URINALYSES

"To promote the better examination of urine in the central laboratory of a large hospital," says Doctors C. Pons and E. B. Krumbhaar, Philadelphia General Hospital, in the September issue of the *Journal of Laboratory and Clinical Medicine*, "we have found the following devices to be practical and useful.

1. "Urine tubes and transportation racks: Special urine tubes are provided, made of heavy glass, with spout and blunt conical bottom. They are seven and one-half inches long by one and one-half inches wide (outside dimensions) and have an approximate capacity of 100 ml. This promotes sedimentation and permits convenient float-

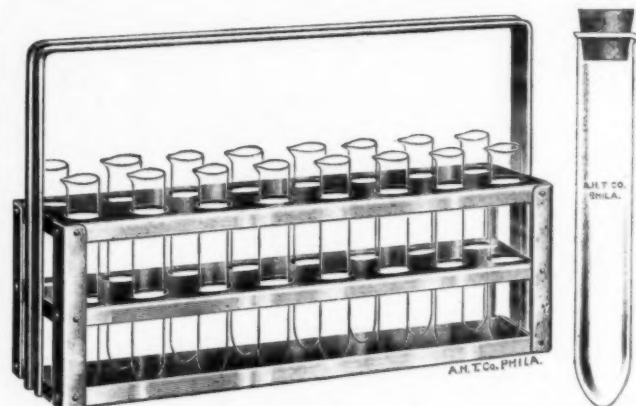


Figure 1. Tray for carrying and examining urine, with special urine tube.

ing of a urinometer, with considerable saving of carriage space over the old sedimentation glasses. The transportation rack (figure 1) has sixteen numbered apertures, corresponding to the numbered tubes, thus reducing liability of confusion. The bottom of the tray is padded with felt or rubber matting to minimize breakage. Loaded racks are supplied to orderlies, as the racks filled with specimens are brought in, each tube containing a few cubic centimeters of a 4 per cent solution of formaldehyde (same as used for tissue fixation, to prevent alkaline decomposition of urine) securely corked. The laboratory slip is folded, wrapped about the tube and held with a metal clip. The advantages of this system are: (1) A uniform method of collection; (2) curtailment of handling specimen in the laboratory; (3) decomposition is minimized; (4) centrifugation is as a rule necessary; and (5) the caliber and capacity of the test tube permits the specific gravity to be taken therein.

2. "Albumin test: For the heat and acetic acid test for albumin, Kolmer's wire rack is used with sixteen ordinary medium sized test tubes of thin glass, placed in a row of eight each. These are two-thirds filled with urine and heated simultaneously with a fishtail burner that covers five tubes at a time. This not only effects a considerable saving of time, but minimizes boiling over

*The Highland
Hospital
Oakland, Cal.
Henry F. Meyers,
Architect*



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Post Graduate Hospital
New York
Contagious Disease
Hospital, Chicago
Perkins Institute
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New Haven Hospital
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Christian Science Ben.
Association, Brooklyn
Santo Tomas Hospital
Panama
Queens Hospital
Honolulu
Jewish Hospital
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New York
Paterson Gen. Hospital
Paterson, N. J.
Niagara Falls Memorial
Hospital
Niagara Falls, N. Y.
Maternity Hospital
Cleveland, Ohio
Kern County Hospital
Bakersfield, Cal.
St. Joseph's Hospital
Kitchener, Ont.
Santa Fe Hospital
Los Angeles, Cal.
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Buffalo City Hospital
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INQUIRE of any of these nationally known hospitals not only if their Jewett Refrigerators are satisfactory and extremely economical—but also if they are showing signs of wear—for no Jewett has ever worn out or had to be replaced.

Over 76 successful years experience in the manufacture of high grade refrigerators for hospitals, homes, hotels and clubs has given Jewett an enviable reputation for workmanship and service.

The continually growing list of installations would indicate that leading Hospital authorities con-

sider the Jewett organization as the foremost manufacturer of quality refrigerators in America.

If you will send us floor plans our Engineering Department will design refrigerators (storage, diet kitchen or mortuary) to fit your particular requirements and write complete specifications without any obligation on your part.

*Write for the Jewett Catalogs and our
free co-operative engineering service*

THE JEWETT REFRIGERATOR COMPANY

134 Chandler Street

Established 1849

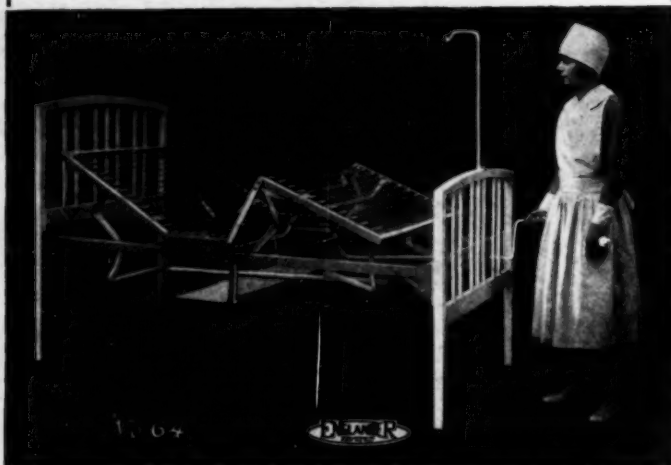
Buffalo, N. Y.

(22)

JEWETT
REFRIGERATORS

When using advertisements see Classified Index, also refer to YEAR BOOK.

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ENGLANDER HOSPITAL BED NO. 64
3 ft. size, double-link spring
fabric. In French gray or brown
rust-proof enamel. Towel rack
and tray holder. Can be had
with extra-size rubber casters.

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ENGLANDER Hospital Beds

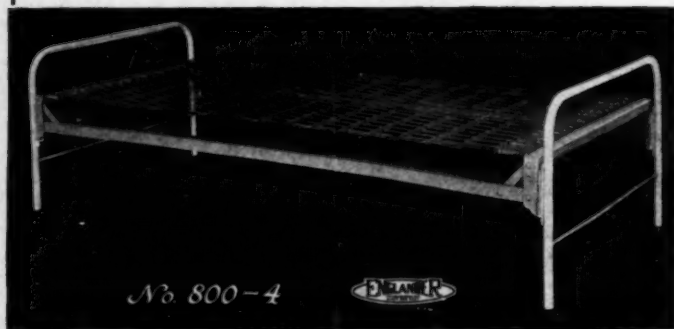
Hospitals of the first rank throughout the country are equipped with Englander Beds and Cots. Englander products have won this preference because of their scientifically correct and sanitary construction, their unusual comfort, their great utility and their long life—Englander Beds are built to endure.

For every hospital need there is an Englander Bed, especially designed to meet that need supremely well. Every buyer of hospital equipment should have in his files the Englander Catalogue No. 25, illustrating hospital beds of all types—write for a copy today.

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PRODUCTIONS FOR
SLEEP AND REST



ENGLANDER HOSPITAL BED NO. 800-4
3 ft. size, three-piece bed, enamel finish.

and breakage. The rest of the test is performed in the usual manner. To promote the consistent reading by different interns of the amount of albumin present, Doctor Karr of the biochemical laboratory has prepared a permanent series of tubes corresponding to "faint trace" "trace" and so forth, up to "heavy cloud." These consist of sterile formalinized gelatin, containing increasing amounts of albumin in the upper half of the tube hermetically sealed. Against a black background these give a very fair comparison with the urine being tested.

"Purdy's method for the detection of albumin is used, except that instead of using a 50 per cent solution of acetic acid, we use a 25 per cent solution. We have found this test as sensitive as, and no more trouble than, the heat and acetic acid test. Mucin, which is present in many urines, and which gives a positive test by other

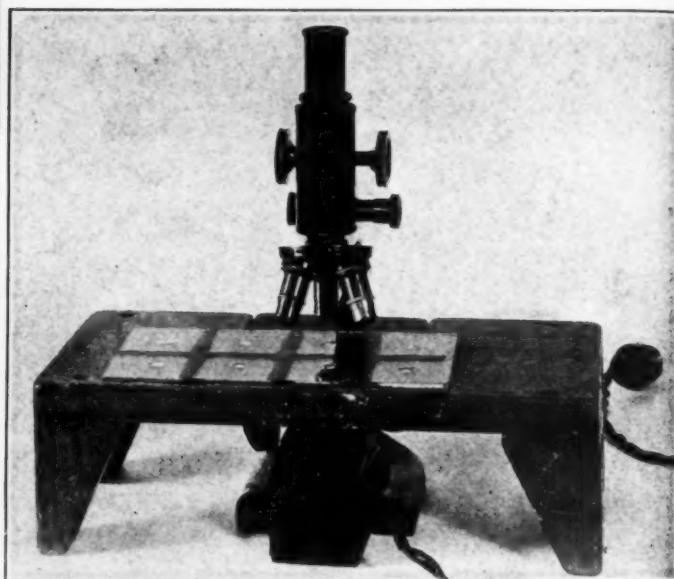


Figure 2. Special microscope stand and mammoth slide for examination of urine sediments.

methods, is held in solution by the saturated sodium chloride, as used in Purdy's method. While we agree that it is better to filter all urines for any albumin test, with this method necessary filtration is reduced to a minimum.

3. "Qualitative sugar: Benedict's solution is used exclusively in this laboratory. Forty-eight tests are done simultaneously by immersing a Kolmer rack in a boiling water-bath for two and one-half minutes. The timing is important, since longer boiling may give fallacious reductions.

4. "Quantitative sugar: For the last six months we have used Sumner's dinitrosalicylic acid colorimetric method with the following advantages over the Benedict method. Under our conditions, interns' errors are less frequent. It is not expensive and there are fewer steps and no calculations. It has the further advantage that any number of tests can be done simultaneously. To save time practically all the solutions used are placed in aspirator bottles.

5. "Microscopic examination: To save time, without loss of accuracy, several pieces of ordinary glass, about four by eight inches are prepared. These are divided by heavily painted lines into eight compartments each of which is about two inches square. The usual microscopic stage is extended by a wooden table thus permitting the free movement of the large slide under the objective. The urine from the conical ends of the original containers is pipetted off, eight at a time, a

Athey

(Patented)

Cloth-Lined Metal Weatherstrip

**The only Weatherstrip that
makes a perfect seal for
both wood and metal sash**

Athey is the *only cloth-lined metal* weatherstrip made. And experience has proved that a cloth to metal contact is the only one that provides a perfect "seal" against drafts and dust.



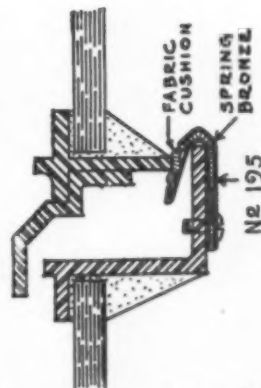
Double Size

Athey Cloth-lined Metal Weatherstrip for wood sash. The cloth-to-metal contact keeps out all drafts, dust and noise, yet is sufficiently pliable so the windows can be opened easily.

It can be used on either wood or metal sash. Leading manufacturers of steel sash recommend it as the best obtainable for use with their product.

**Keep out drafts and soot
Cut coal and cleaning bills**

The elimination of drafts has a direct bearing on the coal bill. Figures taken from several installations show that the reduction in the amount of coal used, after the installation of Athey Weatherstrip, is sufficient to pay the entire cost in a year or two.



Athey Cloth-lined Metal Weatherstrip for drawn steel windows. Notice the cloth and spring bronze contact. This strip is recommended by leading manufacturers of steel sash as the one practical and efficient weatherstrip made.

Athey Products

Perennial Window Shades
Cloth-Lined Metal Weatherstrips
Athey Disappearing Partition
Athey Skylight Shades



Write for complete information and prices

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WEAVING equipment, materials, instructions, diagrams and patterns. The Boston school of Occupational Therapy considers the Shuttle-Craft course of instruction as invaluable to workers in this field, and highly recommends it.

The SHUTTLE-CRAFT COMPANY, Inc.

14-K, Ash Street, Cambridge, Mass.

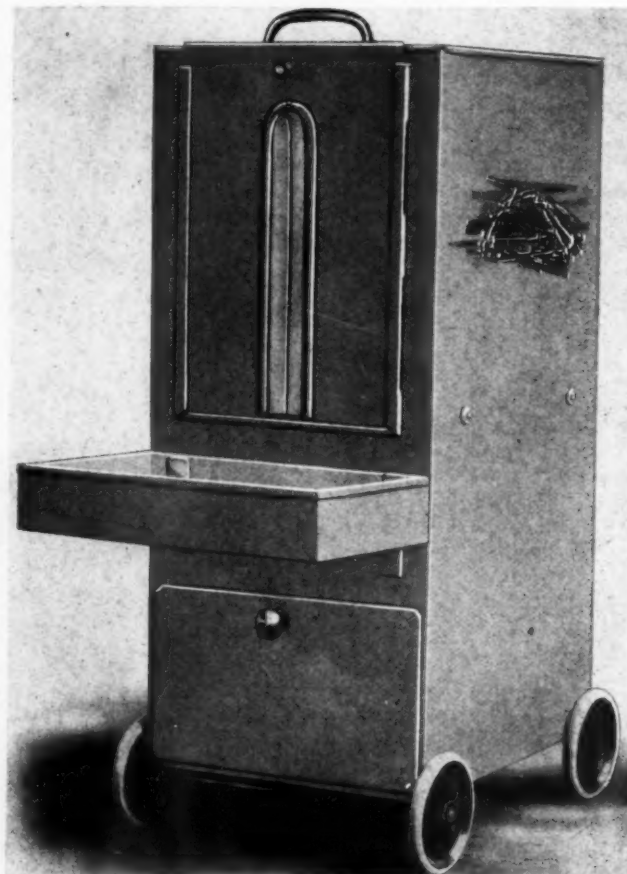
washed pipette being used for each specimen. As the pipette is simply a piece of tubing drawn to a blunt point, a large number of them can always be available. Unless the high power is needed in an exceptional case, cover glasses are not needed, and the eight sediments can be examined long before any harmful drying has taken place. The two-inch square provides an extra large area for the accommodation of a large sample of urine.

"A rotating rubber stamp, with a capacity for twelve letters is used for the intern's signature. With over 100 urines daily this constitutes a considerable saving of time."

PORTABLE SANITARY DUST RECEIVER

The accompanying reproduction illustrates the new dust receiver that has been made available to hospitals by an eastern manufacturer. With this device, the maid can shake the dry mop when and where needed, instead of walking to the nearest exit or window, not infrequently at some distance.

The vertically sliding door is provided with an eighteen-



The dust receiver is easily wheeled from room to room.

inch slot, guarded by a flexible rubber strip. This door enables the mop to be placed inside the receiver, and shaken vigorously, and beaten against the heavy wire rods placed directly over the receiving pan. This pan has a capacity of one-half bushel.

Of all-steel construction, the device is equipped with rubber-tired wheels, and weighs twenty-five pounds. For the larger hospitals, Receiver No. 2 is made, this size having a capacity of one bushel.

1883-1926!

DATES! That is all—unless you look back of the figures and see what they mean and how important they are to you.

They symbolize, first of all, forty-three years of experience, specialized experience, in serving you and thousands of other users whose requirements are similar to yours. They denote a reputation for quality and fair dealing, for only such a reputation could so long endure. They mean dependability!

1925 saw the same steady rate of increase in the number of patrons served as has marked previous years. We can still point to a perfect record of deliveries on contract orders placed with us. More buyers than ever before took advantage of this service of protection against price fluctuations.

May our gratitude for growth show itself in our capacity for service. In this spirit we welcome the new year and its opportunities. May it be rich in achievement for us all.

JOHN SEXTON & CO

WHOLESALE GROCERS ~ Chicago



*America's Largest Distributors
of No. 10 Canned Foods*



..a really modern railroad hospital

*the dust-proof, draft-proof,
noise-proof Missouri-Pacific
at St. Louis*

Chilling winds never whistle in past the windows, nor do noises from busy Grand Boulevard ever disturb the patients within. No dangerous draughts sweep down the corridors . . no dusty, germ-laden air reaches patients' quarters . . unevenly heated rooms and cold floors are unknown.

For Monarch *Interlocking Metal Weather strips* are on all windows and doors.

Monarch *Interlocking Metal Weather Strips* are made to keep costly cold air outside of hospitals and money-made heat in. Made to prevent hospital windows from rattling, and dust and dirt from seeping in. Made to last as long as the hospital itself, and to always work as well as when new.

But . . get all the facts! A post-card request will bring you the whole Monarch story.

MONARCH METAL PRODUCTS CO.

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Manufacturers of Monarch Metal Weather Strips for
Wood Windows, Doors and Pivoted Steel Factory Sash
Representatives in all Principal Cities

MONARCH

METAL WEATHER STRIPS

A METHOD FOR CALCULATING DEPRECIATION COSTS

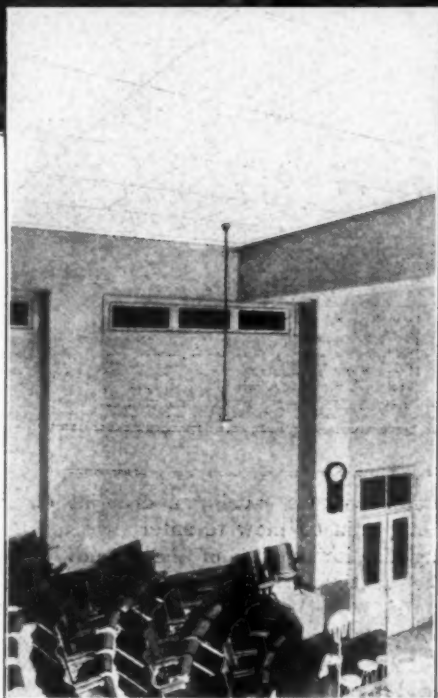
In planning the financial scheme for the hospital erected in memory of his wife, Frederick M. Ingalls, Harvey, Ill., provided for the establishment of a depreciation, or renewal, fund that would automatically take care of replacements. Since much of the equipment essential to a hospital is unknown to a factory the same method of calculation used for his factories could not be used for the hospital. After consultation with the U. S. Department of Commerce, hotel and hospital architects and various physicians he arrived at what he deems to be an accurately determined rate of depreciation for all hospital construction and equipment.

For the benefit of those who may be working to determine depreciation rates, Mr. Ingalls' depreciation list is printed here:

INGALLS MEMORIAL HOSPITAL DEPRECIATION BY CLASSES OF ASSETS

	AMOUNT	RATE	DEPRECIATION
Buildings—			
Hospital proper	\$108,812.82	2%	\$ 2,176.26
Nurses' hall	30,759.48	3%	922.79
Boiler and laundry bldg.	22,843.30	2½%	571.08
Boiler stack	2,150.00	2½%	53.75
Garage	838.84	new	0.
Equipment—			
Elevator	5,000.00	5%	250.00
Refrigerator, and system }	3,703.00	7½%	277.73
Nurses' stove			
Kitchen equipment }			
Laundry machinery			
Sump pumps	8,088.80	10%	808.89
Typewriter			
Sewing machine			
X-ray			
Awnings and screens }	7,262.43	25%	1,815.61
Sterilizing equipment			
Wheel chairs and stretchers			
Operating rooms	12,084.67	5%	604.24
Boilers and stokers			
Water tank and water softeners			
Medical supplies	492.63	100%	492.63
Heating, plumbing and electric wiring.	50,808.15	5%	2,540.41
Furniture, fixtures and decorating.			
composition flooring	2,265.00	10%	226.50
Lighting and toilet fixtures }			
Clock			
Laboratory tables and rack			
Filing cabinets	3,746.09	5%	187.30
Bedside tables			
Radio			
Lamps			
Lockers			
Linoleum			
Reed, dining room and office furniture	3,026.73	10%	302.66
Dressers, chairs }			
Beds and springs			
Mattresses and pillows	10,920.48	7½%	819.01
Class room furniture			
Silverware			
Bed screens	277.18	15%	41.58
Rugs, carpets, shades, and draperies	3,038.05	20%	607.60
Bed linen	2,585.79	66¾%	1,723.86
Table linen, china glassware	782.55	50%	391.18
Kitchen utensils	42.12	33½%	13.94
Painting and decorating	1,434.75	50%	717.38
Night lamps	612.00	100%	612.00
Bronze tablets and handling	468.75	0	0
Lawn tools	264.25	10%	26.43
Small tools	20.30	20%	4.06
Miscellaneous—			
Laundry equipment			
Baby scales			
Linen hampers	699.72	10%	69.98
Office furniture			
Cotton blankets	266.94	66¾%	177.96
Rubber sheeting, gloves and gowns.	117.15	50%	58.58
Bandage and cotton cabinets }			
Trucks, racks, stretchers			
Fire extinguishers			
Operating tables			
Operating instruments	2,361.73	5%	118.10
Anesthesia equipment			
Laboratory equipment			
Electric heater	7.88	20%	1.58
Medical and surgical supplies	80.55	15%	13.58
Plugs, fuses, incandescents	48.99	100%	48.99
Kitchen utensils	612.69	33½%	204.23
Glass and chinaware	254.91	50%	127.46
	\$287,588.52		\$17,126.45

Quiet



This operating room in the Polyclinic Hospital, New York City, is quieted with Johns-Manville Acoustical Treatment.

BY quieting the many unavoidable noises of your hospital with Johns-Manville Acoustical Treatment, you reduce the nervous wear and tear they inflict on your patients, while your doctors and nurses finish their tours of duty feeling far fresher because of the restfulness it brings.

This treatment succeeds where "Silence" signs fail. Write us for details.

JOHNS-MANVILLE INC., 292 MADISON AVE. AT 41st ST., NEW YORK CITY
Branches in 64 Large Cities For Canada: Canadian Johns-Manville Co., Ltd., Toronto

JOHNS-MANVILLE Acoustical Treatment

This pattern was made especially for the Blodgett Memorial Hospital.



Syracuse China meets the exacting requirements of the modern hospital



THE BLODGETT MEMORIAL HOSPITAL
GRAND RAPIDS, MICHIGAN

Syracuse China is attractive—graceful in shape, beautiful in coloring. Its use quite naturally makes for more appetizing, enjoyable meals in the sick wards.

Syracuse China is completely vitrified—therefore non-porous and germ-proof. This makes it exceedingly easy to wash and keep clean.

Syracuse China is strong. It resists breakage, chipping, cracking. But when accidents do happen, it may be quickly replaced.

The Syracuse China line is complete. Meets every hospital need with both open-stock patterns and made-to-order designs with individual crest or monogram.

Beautiful. Efficient. Economical! There is a Syracuse dealer near you. Ask him for samples and prices—or write us direct.

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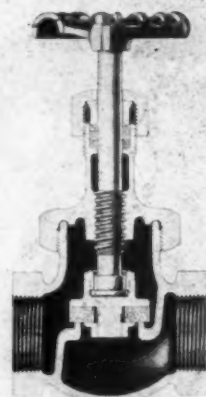
SYRACUSE CHINA

VALVE WITH COMPOSITION DISC SEAT

According to a recent announcement, a new line of medium pressure bronze globe and angle valves for 225 pounds working steam pressure has been developed. A sectional view of the new valve accompanies. This line fulfills a need for a valve with the renewable disc feature that will satisfactorily meet higher pressures than recommended for use with the standard pattern valves.

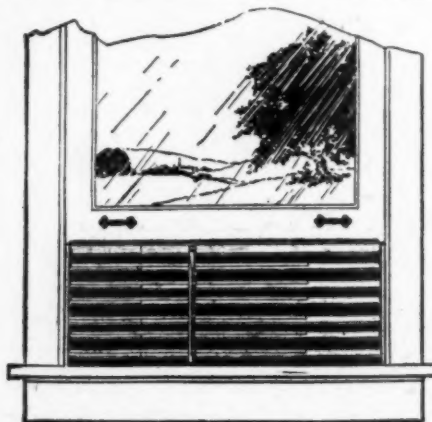
An important feature of this valve is the bonnet and union, made in one piece to screw on to the outside of the body threads. This construction gives added strength to the body end, while the bonnet hexagons, made especially large, allow for removal without distortion. This provides rugged and durable construction in addition to easy access.

A composition disc for a high-pressure valve will appeal to those who recognize the superiority of such a disc over the metal-to-metal seat. No regrinding is necessary to insure a tight valve. The spindle is of manganese bronze, with large, powerful threads that are all in contact when the valve is closed. The stuffing box is deep, with plenty of asbestos packing which is compressed by means of a bronze follower. The valves are furnished in sizes ranging from one-fourth inch to three inches.



METAL WINDOW VENTILATOR

A metal window ventilator that will fasten on any window has been designed particularly for hospital use. The air is forced through the ventilator directly toward the ceiling so that a maximum of air may be had through



the open window without causing a draught on the patient or allowing rain or snow to enter.

In installing the lower sash of the window is lowered on top of the ventilator. The lateral adjustment that makes it possible to fit the ventilator tightly into the window frame prevents all possibility of its being blown down or pushed out the window. The ventilator is easily removed, adjusted or closed.

In 610 A. D., St. John, the almoner, established a hospital at Alexandria, Egypt.

Diet—*Medicine's Ally*



We are glad to send free samples of Shredded Wheat to physicians and heads of sanitariums and hospitals on request.

The Shredded Wheat Company
Niagara Falls, New York

PHYSICIANS who know Shredded Wheat endorse its efficacy in treating all cases where proper diet is essential. Indigestion and sluggish peristalsis readily yield to the properly balanced proteins, carbohydrates and mineral salts in this famous whole-wheat ration.

Shredded Wheat

"Wear-Ever"

Aluminum Kitchen Ware

WHEN "Wear-Ever" aluminum was adopted as standard equipment in the kitchens of the Jefferson Hospital, Philadelphia, the management at one stroke insured these advantages for the institution:

Better-cooked, better-flavored foods; the elimination of retinning expense; a daily saving in fuel; and the utmost in sanitation and purity in the preparation of foods.

Write for particulars regarding the advisability of equipping the kitchens at your institution with "Wear-Ever".

THE ALUMINUM COOKING UTENSIL COMPANY
New Kensington, Pa.



Jefferson Hospital, Philadelphia, where the kitchens are completely equipped with "Wear-Ever".



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ELECTRO CARDIOGRAPH
BOCK-THOMA
EXCLUSIVE M-SCHAEFER-S-A-BERNE MODEL

THE EPOCH MAKING "UNIVERSAL" REGISTERING APPARATUS. INDISPENSABLE TO EVERY AMERICAN CLINIC. RECORDS SIMULTANEOUSLY ELECTRO CARDIOGRAMS AND HEART MOTION, PULSES, HEART SOUNDS.

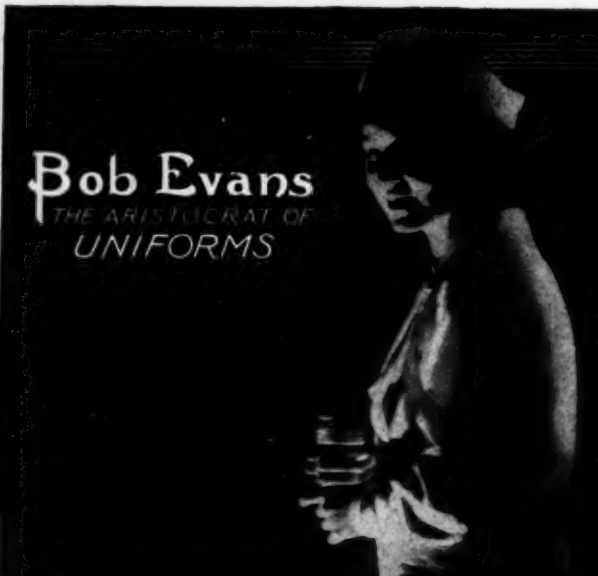
ONE PERFORMANCE PRODUCES UP TO

T W O	CARDIO	ONE	PULSE	T W O
	GRAMS +	HEART	CURVES	
	SOUND	CURVE	SOUND	

BRILLIANT EFFICIENCY * ACCURATE RESULTS * TECHNICALLY CORRECT * PRECISION WORKMANSHIP * INSENSIBLE TO INDUCTIVE CURRENTS * NEW ISOLATION OSCILLOGRAPH * SETTING UP AND HANDLING SIMPLE AND EASY * UNSUSCEPTIBLE TO OUTSIDE NOISE * DESIGNED AND DEVELOPED IN COOPERATION WITH THE WORLD'S MOST EMINENT AUTHORITIES IN ELECTRO CARDIOGRAPHY * MAKE SURE OF NAME AND IDENTIFICATION STAMPS TO GUARANTEE ABSOLUTE ORIGINALITY *

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COMPLETE HOSPITAL EQUIPMENT ★ Write for Bulletin ★ A3 ★ HAND-FORGED SURGICAL INSTRUMENTS



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THE ARISTOCRAT OF
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Because they are made so well, because they fit so smoothly, because they launder so beautifully—and because they are Bob Evans Uniforms.

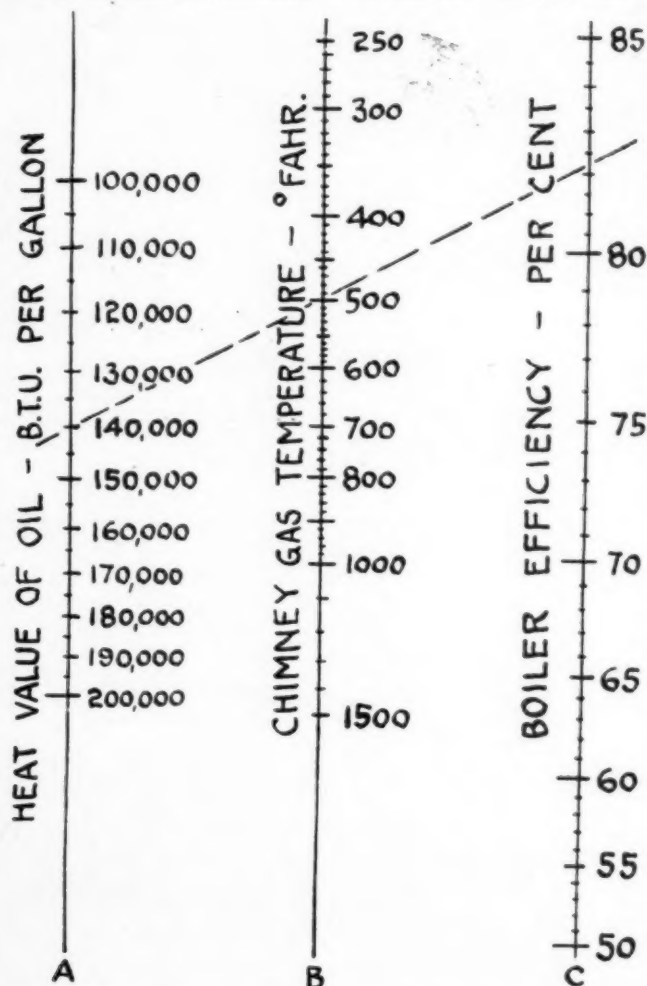
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New York Office, 1182 Broadway

HOW TO DETERMINE THE EFFICIENCY OF OIL-FIRED BOILERS

The accompanying chart is used to determine the approximate efficiency of any oil-fired boiler, provided that the heat value of the oil and the flue gas temperatures are known.

The method of procedure is as follows: Simply run a



straight line through the heat value of the oil in B. T. U. per gallon in column A, through the chimney gas temperature in degrees F., column B, and the intersection of the straight line in column C gives the approximate percentage of boiler efficiency.

As an example, the dotted line shows that if the heat value of oil is 140,000 B. T. U. per gallon and if the chimney gas temperature is 500 degrees F., the boiler efficiency should be about 82.2 per cent.

The chart is based upon the following simple rule which is satisfactory for ordinary use. "Multiply the chimney gas temperature in degrees F. by 5,000 and divide by the heat value of the oil in B.T.U., per gallon. Subtract the result from 100, and the remainder is the approximate boiler efficiency in terms of per cent."

Applying this rule to the above example where the temperature is 500 degrees F. and the heat value of the oil 140,000 B. T. U. per gallon, multiplying 500 by 5,000 gives 2,500,000. Dividing by 140,000 the quotient is 17.8. Subtracting from 100 the result is 82.2 per cent, as shown by the chart.

A careful study of the chart shows how important it is to maintain a low chimney gas temperature, thereby avoiding high temperatures. It also shows that oils of high

Gall-Bladder Visualization

A *serial* examination of the gall bladder using Tetraiodophenolphthalein is becoming as important a routine in all obscure cases of gastro-intestinal disturbance, as the barium meal series.

Eastman Tetraiodophenolphthalein, sodium salt is pure and safe. Its use for this series with Eastman Duplified X-Ray Films, *Super-Speed* assures the maximum detail in gall-bladder radiographs.

Literature on request

Eastman Kodak Company

Medical Division

Rochester, N. Y.

Beautiful Waxed Floors

this new easy way

*Now You Can Wax
your floors QUICKLY
—without stooping
—kneeling or soiling
your hands*



POLISH FLOORS ELECTRICALLY

This Electric Floor Polisher is a marvelous, new machine that instantly and without labor brings waxed floors and linoleum to a beautiful high gloss.

Simple! Compact! Light in weight. Easier to operate than a vacuum cleaner. Runs from any light socket for less than 2c an hour. It polishes under buffets, davenport, beds, etc., without moving the furniture. Sturdily built to last a lifetime and guaranteed absolutely.

Wax Preserves Wood

"Wax is like armor for floors—tramping feet never actually touch the floor. And after a floor has been waxed the daily cleaning is simple. Wet mopping is entirely unnecessary.

Every evening simply remove the surface dirt by sweeping. Re-waxing may be necessary on the main traveled areas once or twice a month. A scrubbing should be required not more than two, three or four times a year.

\$42.50

COMPLETE READY
TO OPERATE

UNIVERSAL HOSPITAL SUPPLY CO.

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Write for Complete Catalog of Guaranteed
Hospital Supplies and Equipment

value are apt to give higher boiler efficiencies than are oils of low heat value, the chimney gas temperature being the same in all cases.

A similar chart based on coal has been successfully used for many years.

METHODS FOR EXTERMINATING MOTHS

Clothes moths cannot be kept from attacking wearing apparel as there is no known method that will make clothing absolutely immune to their depredations. Constant watchfulness is necessary for successful control. If possible, fabrics should be thoroughly beaten, brushed and sunned, before any treatment is applied. Naphthalene in the form of flakes or moth balls is one of the safest and best ways of protecting fabrics against moth injury.

To get definite results naphthalene should be used in tight chests, trunks or other containers where the fumes given off by the slow evaporation will be confined. Paradichlorobenzene is a relatively new substance that is quite as effective as naphthalene in moth control. Gum camphor is less powerful than these two, and will protect if used at the rate of from one-half to one pound to each five cubic feet of space in tight containers.

Cold storage is one of the best methods because it eliminates all chance of error by the owner. Sleeping quarters may be fumigated with hydrocyanic acid gas during the day and ventilated so that they may be occupied the same night. Dry heat and sunning are also recommended, but the temperature must be kept at 130 degrees F. long enough to heat thoroughly the articles to be treated.

BEDDING THAT CREATES A FAVORABLE IMPRESSION

Bed linen and blankets are certain to become stained through constant usage. While such stains do not in any way destroy the usefulness of the textile or indicate poor housekeeping, they do give bad impressions to visitors or patients just coming into the institution. One superintendent of a small town hospital always makes certain that clean, white, fresh linen is used in making up a bed. This eliminates the possibility of an unfavorable first impression from incoming patients.

DROP LEAF TABLES FOR TRAY SERVICE

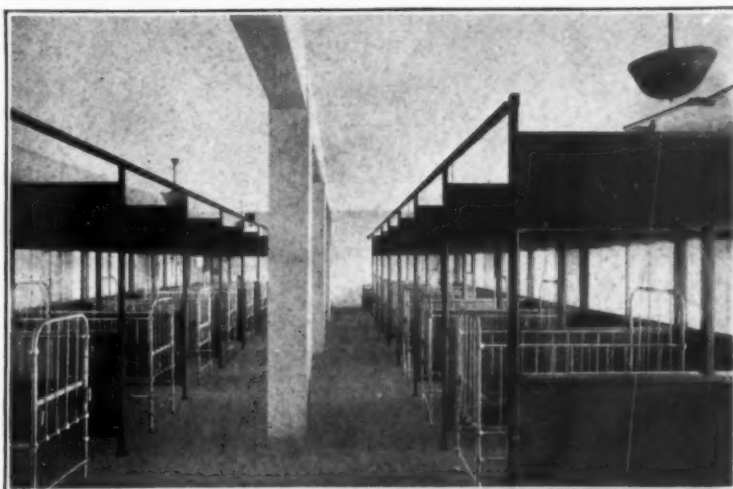
Where the diet kitchens on the various floors are too small to permit of long tables or portable racks, thus making the arrangement of trays an inconvenience, a drop leaf table can be built against the corridor wall just outside the diet kitchen door. This drop leaf table, lifted and used during the meal hours, can be dropped out of the way during the afternoon and night, or when it is necessary to allow for the passage of a stretcher, cart or wheeled chairs.

PAINTING OLD FURNITURE

A small New England hospital that had been thoroughly remodeled had no funds for the purchase of new furniture. However, this problem was partially solved by having the old furniture thoroughly cleaned and hand painted in colors. Most of it was done in a French grey with light blue trimmings.

WEISTEEL

TRADE MARK
REGISTERED



Weisteel Cubicle Installation in
Willard Parker Hospital, New York City

S. W. Wyne, Acting Director
Bureau of Hospitals, City of New York

Ideal for Semi-Private Wards

WEISTEEL Hospital Cubicles provide an excellent means, at reasonable cost, of filling the need for semi-private ward cubicles and are meeting with a steadily-growing increase in use.

Hospital authorities are recommending cubicles because of the following advantages:

1. Alleviation of cross infection.
2. Permit greater classification.
3. Segregation according to condition and ailment.
4. Cross ventilation without noticeable draft.
5. Reduction of nurse's travel.
6. Greater privacy and increased quiet.
7. Patients do not face the daylight.

Weisteel Cubicles are strong, quickly cleaned, sanitary, economical and permanently handsome. The Weisteel Professional Service Plan is for your convenience and economy. Just send a simple layout of your space. Complete recommendations and quotations will be sent you with no obligation attached.

Weisteel Professional Service Plan

Saving Time Saving Cost

A corps of experienced engineers is maintained for the convenience of Weisteel users. Just send a simple layout of your room space to our factory office. These engineers will lay out complete specifications, taking full advantage of your facilities with a minimum cost to you. Quotations and specifications will be sent you with no obligation attached.

Cubicles will come to you (after acceptance of quotations) with simple diagram and erection instructions, so that your building handy man can quickly and quietly install them. No worry, no bother, no cost of unnecessary items or specialized labor.

Architects specify more Weisteel Compartments than any other make.

WEISTEEL

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HOSPITAL CUBICLES

HENRY WEIS MANUFACTURING CO.
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Toilet, Shower and
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Compartments

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Hospital
Cubicles

Representatives in All Principal Cities

NEWS OF THE HOSPITALS AND SANATORIUMS

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

Arkansas

Greeks Plan Sanitarium for Hot Springs.—The Greeks of Little Rock and Hot Springs have been granted a charter for the erection of a modern sanitarium at Hot Springs to be known as the "Asclepius Sanitarium" at a cost of \$250,000.

California

Dr. Smith Turns Over Hospital to Dr. Yoakum.—Dr. Hugh Smith, for six years physician of Newman, has sold his hospital to Dr. C. A. Yoakum, Chowchilla, who took possession of the hospital, December 1.

Chapel Planned for Sonoma Hospital.—Announcement has been made that the Christian Endeavor of Sonoma County will raise the money to erect a chapel and other rooms at the Sonoma County Hospital, Santa Rosa.

Colorado

Colorado Sanitarium to Enlarge.—The Colorado Sanitarium of the Seventh Day Adventist Church is planning to build a \$25,000 addition to the sanitarium at Boulder.

Denver May be Site for War Mothers' Memorial.—Another step in the location of the proposed \$2,000,000 hospital in memory of the war mothers of the country was taken at a meeting of the directors recently at which the suitability of Denver as a site was favored. The hospital as planned, will have a capacity of 4,800 beds for dependent mothers and other relatives of soldiers, particularly those suffering from tuberculosis.

Connecticut

Yale Opens Clinics to Physicians of the State.—Yale University school of medicine, New Haven, has opened its clinics to physicians of the state.

Awarded Fellowship at Jewish Hospital.—Dr. David H. Shelling, Hartford, has been awarded the newly established Cuplan research fellowship in pediatrics at the Jewish Hospital, Brooklyn.

Florida

New Infants' Hospital for St. Luke's.—Announcement has been made of the construction of a new infants' hospital in connection with St. Luke's Hospital, Jacksonville.

Exchange Club to Help Furnish Rooms at Good Samaritan Hospital.—The Exchange Club has voted to raise a sum of at least \$15,000 towards furnishing bedrooms in the addition to the Good Samaritan Hospital, Palm Beach.

Georgia

Two New Buildings for Clark Co. Sanatorium.—A thirty-bed infirmary and a service building have recently been completed for the Clarke County Sanatorium, Athens.

Idaho

Funds for Nazarene Hospital.—Funds are being raised at Nampa for the erection of a \$60,000 general hospital.

Illinois

Hillcrest to Enlarge.—"Hillcrest," the Adams County Hospital, Quincy, will erect a fifty-bed addition.

St. Bernard's Hospital Reorganized.—Following its affiliation with Loyola University, Chicago, St. Bernard's Hospital has reorganized its staff.

Dedicate Hospital at Orphans' Home.—The new hospital recently opened at the Soldiers' Orphans' Home, Normal, will increase the bed capacity to sixty-five.

Dr. Williams Chief Surgeon of West Frankfort Hospital.—Dr. J. E. Williams is chief surgeon of the West Frankfort Union Hospital, West Frankfort. Dr. D. R. Gaskin who was recently mentioned in these columns as chief surgeon and manager holds the position of assistant chief surgeon and manager of the hospital.

Dr. Read Joins Loyola Medical Faculty.—Dr. Charles F. Read, formerly superintendent of the Chicago State Hospital, Dunning, has been appointed head of the department of nervous and mental diseases, Loyola University Medical School and has taken up private practice in nervous and mental diseases in Chicago.

Resthaven Sanitarium Adds Occupational Therapy Department.—A department of occupational therapy has been added to the Resthaven Sanitarium, Elgin. The department will be in charge of a trained occupational therapist and will provide work for general and specialized cases of nervous and mental diseases.

Mrs. Dixon Re-elected Head of Wesley Woman's Auxiliary.—Mrs. George W. Dixon has been re-elected for the eighteenth year as president of the woman's auxiliary of the Wesley Memorial Hospital, Chicago. The auxiliary has pledged cooperation with the board of the hospital in its plans to erect the new \$20,000,000 hospital in connection with the Northwestern University on McKinlock campus, Chicago.

St. Anne's Plans \$1,000,000 Hospital.—Plans have been prepared by Architect Herman J. Gaul, Chicago, for the \$1,000,000 four-story hospital to be built on a ten-acre tract at Laverne and Lamon avenues, for St. Anne's

WATCH THIS SPACE NEXT MONTH

FOR REPORT OF THE CAMPAIGN IN ONTARIO FOR A MEMORIAL TO ONE OF CANADA'S MOST DISTINGUISHED PHILANTHROPISTS, who died August 15, 1925, leaving his unfinished work for Tuberculosis Sufferers to be carried on by worthy successors.

TO YOU *from failing hands*
I THROW THE TORCH
Be Yours to hold it high



The Late Sir Adam Beck,
founder and president of
Queen Alexandra
Sanatorium

Death's intervention
thwarted Sir Adam's
decision to lead this
campaign. Dying, he
committed this great
unfinished work to those
he served—to YOU!

Spiritual Last Will and Testament

(As Expressed by Sir Adam shortly before his death)

TO THE people of Ontario
I entrust those poor
sufferers from tubercu-
losis, who, in their affliction
turn with anxious hearts to
Queen Alexandra Sanatorium.
God forbid, that their poverty
shall ever bar the door. My
course is ending. Carry on!

Adam Beck

Beck Memorial Endowment
The Queen Alexandra Sanatorium
\$500,000

WARD, WELLS, DRESHMAN AND GATES
 Metropolitan Tower, New York 612 Wrigley Bldg., Chicago

For the Promotion of Healthful Requirements



Butler Memorial Hospital,
Butler, Pa.
E. Tilton and
E. O. Mellon,
Architects.



NOWADAYS Steel Windows are a necessity in the strictly modern hospital, not only from the standpoint of fire-safety but for cleanliness, adequate daylight and most efficiently controlled natural ventilation.

Truscon Projected Steel Windows insure the maximum efficiency in daylighting. They meet requirements of natural ventilation, but always with proper deflection to prevent draught. They have a fine appearance and architectural character.

Write for illustrated catalog and full information

TRUSCON STEEL COMPANY, Youngstown, O.

Warehouses and Offices in All Principal Cities.

Foreign Trade Division, New York. The Truscon Laboratories, Detroit, Mich. Trussed Concrete Steel Company of Canada, Ltd., Walkerville, Ont.

TRUSCON

STEEL WINDOWS

Hospital. The building will have 125 private rooms. The present structure at 4900 Thomas street will be converted into a nurses' home. The hospital is under the supervision of the Poor Handmaidens of Jesus.

Holds Parcel Post Sale for Passavant Improvements.—The Hospital Aid Society of the Central Christian Church, Jacksonville, held a parcels post sale November 23, the proceeds of which were used for the improvement and enlargement of the dining room and kitchen of the Passavant Hospital. The society also recently pledged \$150 to furnish the office of the new isolation building.

Pound Party for Sherman Hospital.—A pound party at which attendants donated a pound or more of food was held November 24, by the Elgin Woman's Club, Elgin, for the benefit of the Sherman Hospital.

Iowa

Mercy Hospital, Council Bluffs, to Enlarge.—Excavation has begun for the proposed addition to Mercy Hospital, Council Bluffs, to be constructed at a cost of \$150,000. The addition will consist of four stories and basement covering an area of 45 by 91 feet.

Kansas

Catholic Hospital for Emporia.—A site has been purchased for the erection of a \$300,000 Catholic hospital at Emporia, to be started this spring.

Massachusetts

Dedicates New Maternity Hospital.—The Florence Crittenton League of Compassion has dedicated a new maternity hospital and home on the site of the old Peter Faneuil homestead, Oak Square, Brighton.

Donation Party Held for Homeopathic Hospital.—A donation party of blankets, sheets, pillow slips and other articles for hospital use was recently held by the Ladies' Aid Society for the Homeopathic Hospital, Newburyport.

Michigan

Nine Counties Plan Tuberculosis Hospital.—Nine counties from both the upper and lower peninsulas of Michigan are considering action toward the erection of county tuberculosis sanatoriums, since the enactment of the new county sanatorium law by the Legislature of 1925. The law makes it possible for any county, having a population of more than 30,000 to erect its own tuberculosis sanatorium; it also provides that counties having a smaller population may unite in financing a sanatorium project.

Minnesota

Dr. Norris in Charge of St. Peter State Hospital.—Dr. John F. Norris has been appointed superintendent of the St. Peter State Hospital, St. Peter.

St. Andrew's Hospital Opens Drive.—St. Andrew's Hospital, Minneapolis, has opened a drive for \$200,000 for the erection of an additional 100-bed wing to the hospital.

Lutheran Hospital Dedicated.—Dedication exercises were recently held for the new Lutheran Deaconess Hospital, Minneapolis. The addition will accommodate forty beds, bringing the total capacity up to 150.

Mississippi

In Charge of Nurses and Charity Hospital.—Mrs. Mattie Leahy, R.N., is the new superintendent of nurses at the Charity Hospital, Natchez.



It Took Us Just 10 Days to Raise \$1,600,000 for the Toledo Hospital

HOSPITAL facilities in Toledo, Ohio, were crowded. The need for a spacious and modern structure was quite apparent to everyone. For a time the subject was greatly agitated, but after a while it died down and was almost forgotten. That was a little over six months ago.

Just about that time the Masonic Fraternity of Toledo decided to raise \$1,500,000 for the erection of a huge Temple and Civic Auditorium. They engaged us to manage the campaign. We raised the money in 12 days.

The effect on Toledo's citizenry was decidedly noticeable. Its money power, heretofore unrevealed, gave rise to new hopes and awakened slumbering ambi-

tions. The subject of a new hospital was revived immediately. Official Toledo and its public spirited citizens had followed closely our movements in the successful Masonic campaign. They liked the dignified character of our appeal and the business-like manner in which we conducted the entire campaign. Most of all they were impressed by the atmosphere of good will which we left behind.

Soon after we were engaged to raise the money for the new Toledo Hospital. The quota originally set was \$1,000,000, but was later increased to \$1,250,000 and finally to \$1,500,000. The campaign began November 13th and ten days later we had \$1,600,000.

Are you interested in a dignified method of raising money for a long deferred hospital improvement or annex? If so, write today for a copy of "Success in Raising Money".

Herbert B. Ehler & Company, Inc.
15 Park Row, NEW YORK



SEASONABILITY

NOW that we have entered upon the New Year, the time is seasonable for worthy fund raising campaigns and institutions with development and extension projects will be able to capitalize the revival of national prosperity. In communities where there may be competitive enterprises that one will fare best with its fund raising campaign which earliest gets its project before the people and its drive under way.

Mary Frances Kern has furnished the publicity and organization service which has made success possible for hospitals and other institutions throughout the United States. Her campaign methods have been matured by long experience and they get results.

Mary Frances Kern is not only a campaign executive but also a hospital executive, and her identification with an extension project is usually constructively valuable to the institution from much more than the campaign standpoint.

More detailed information will be gladly furnished upon request and at no cost to any interested hospital official.

MARY FRANCES KERN Financial Campaigns

1340 Congress Hotel

CHICAGO, U. S. A.

8 West Fortieth St.
NEW YORK, N. Y.

73 Adelaide St., West
TORONTO, CAN.

Missouri

Dr. Shankland Heads St. Louis Hospitals.—Dr. J. Wilbur Shankland has been appointed hospital commissioner of St. Louis by the director of public welfare to succeed Dr. G. A. Jordan. Dr. Shankland has been on the faculty of the St. Louis University medical and dental schools for the past ten years and on the visiting staff of the City Hospital for four years and has served as the superintendent of the surgical clinic of St. John's Infirmary.

New Jersey

Englewood Hospital Opens.—The formal opening of the new three-story Englewood Hospital, Englewood, took place November 30. The present building is to be used as a maternity ward.

Christian Sanatorium to Have Nurses' Home.—A campaign for \$75,000 is being planned by the officers and members of the Christian Sanatorium Association, Patterson, for the erection of a new nurses' home and an additional hospital building.

\$700,000 Fire Destroys New Jersey Hospital.—A fire on December 14, completely destroyed the Home of Divine Providence, Paramus Borough, a hospital and home for incurables, causing a loss estimated at \$700,000. All the 175 inmates and patients were safely taken from the burning buildings by eleven sisters who were on duty, and by townspeople attracted by the blaze.

Three buildings including the chapel, hospital and the home proper were destroyed. All were of stone construction.

New York

Harlem Valley State Hospital to Enlarge.—Contracts have been awarded for the construction of a new \$2,900,000 building for the Harlem Valley State Hospital.

Greenpoint to Have Maternity Hospital.—A maternity hospital for the benefit of the people of Greenpoint will soon be established by Monsignor McGolrick, rector of St. Cecilia's church. The hospital will be housed in the three-story building formerly donated as a Catholic high school.

Reconstruction Hospital Has Benefit Music Festival.—The Reconstruction Hospital, New York, held a benefit music festival as one of the opening events of the new Madison Square Garden December 20, a feature of its campaign to raise \$1,000,000 for the new building to be erected on its present site.

Memorial to S. L. Cromwell.—Ten members of the Stock Exchange, New York, have formed themselves into a committee to raise \$100,000 to provide a ward in the Presbyterian Hospital in memory of Seymour L. Cromwell, in recognition of his services to the Exchange during his three terms as president.

Forty-one Nurses Graduated.—Forty-one nurses received diplomas at the twenty-sixth annual graduating exercises of King's County Hospital School of Nursing recently. Following the commencement exercises the graduates, other nurses and students enjoyed a reception and dance held in the gymnasium of the nurses' home.

New Gifts Bring Total Up to \$6,328,691.—The new gifts amounting to \$46,406 for the Presbyterian Hospital, New York, bring the total amount of gifts thus far presented to the institution up to \$6,328,691, according to a recent announcement. The gifts reported include \$10,000 from George Clarke of White Plains with which to endow a bed. The other gifts are anonymous.

Seven Hundred Attend Cornerstone Services.—Seven hundred persons attended the ceremonies accompanying the laying of the cornerstone of the new Caledonian Hospital, Brooklyn, recently. The new building, to cost \$250,-

Western Electric

SUPPLY DEPARTMENT

Changes name—

Effective January 1st, that part of the Western Electric Company known as the Supply Department, takes Graybar Electric Company as its name. This involves no change whatever in the existing distributing organization. Nor does it affect the facilities offered to buyers of electrical supplies all over the country. The significance of the change is found rather in the source of the new name—derived from Gray and Barton, the original business title of the founders of Western Electric in 1869. Pioneers of 56 years' standing in the electrical industry, Graybar looks forward to the next 56 years of service.

GraybaR

E L E C T R I C
C O M P A N Y . . . I N C O R P O R A T E D

SUCCESSOR TO SUPPLY DEPT.

Western Electric



In line with the objective of modern medicine

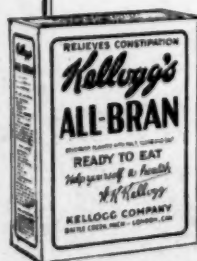
MEDICAL science is constantly striving to prevent suffering and disease. Preventive medicine is the order of the day.

Kellogg's ALL-BRAN is, of course, primarily employed to relieve constipation, but it is equally valuable in preventing constipation, in keeping the intestinal tract open and functioning normally.

Physicians consider Kellogg's ALL-BRAN a reliable ally, because it is ALL-BRAN. When they recommend it, they know that the anticipated results will be accomplished. Whether the cases are mild or chronic, physicians and all of the profession can always rely on ALL-BRAN for natural relief.

Patients like Kellogg's ALL-BRAN. They don't "forget" to take it. Cooked and krumbled by special Kellogg processes, it has a most appetizing flavor—crisp, nut-like, delicious. An enjoyable breakfast dish.

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000, is adjacent to the old Caledonian Hospital, an institution erected and sponsored by Americans of Scotch birth. Frederick Ecker, president of the New York State Chamber of Commerce, laid the cornerstone.

Dr. Bresnahan Goes to St. Mark's.—Dr. John F. Bresnahan, formerly superintendent, James J. Jackson Memorial Hospital, Miami, Fla., has accepted the superintendency of St. Mark's Hospital, New York, succeeding Dr. J. C. McElroy who is now superintendent of the University of Iowa Hospital, Iowa City, succeeding Dr. B. W. Caldwell.

Bronx Hospital Plans \$1,260,000 Addition.—Plans have been announced for the construction of a new group of buildings for the Bronx Hospital, New York, to cost \$1,260,000. The plans which are being drawn by Louis A. Abramson, architect, provide for the construction of a main pavilion seven stories high and several service buildings in addition to an out-patient department, storerooms, laundry and power plant. It is expected to have the main wings completed during 1926.

Many Improvements Proposed for Binghamton Institution.—The New York State Hospital Commission recently approved two large expenditures for the Binghamton State Hospital, Binghamton, one of \$240,000 for the erection of a building for treatment of tuberculous patients and another for \$250,000 for the erection of a cold storage or refrigeration plant. It is believed that these sums will be voted at once, thereby insuring the construction of these two structures next spring. In addition a total of \$87,000 has been assigned for fire protection and prevention.

North Carolina

New Hospital for Iredell County.—A new hospital is to be built in Iredell County, Mooresville, the site for which was donated by S. A. Lawrence.

Dr. Locke Heads Laurel Hospital.—Dr. Eva M. Locke has accepted the position of physician-in-charge of the Laurel Hospital, White Rock, northwest of Asheville.

Ohio

Presents Operating Table to City Hospital.—Dr. Louis A. Witzeman has presented the City Hospital, Akron, with a new operating table.

Gives \$50,000 to Toledo Hospital.—John N. Willys, president, Willys-Overland Co., has made a contribution of \$50,000 to the new Toledo Hospital.

Commission to Operate Hempstead Hospital.—A commission of six members to be appointed by the mayor was recently authorized by the Portsmouth city council to operate the Hempstead Hospital which has been previously managed by the safety department.

Dr. Keyser Heads Tuberculosis Hospital.—Dr. T. L. Keyser, world war veteran and former member of the faculty of the College of Medicine, Western Reserve University, Cleveland, assumed the duties of superintendent of the Clark County Tuberculosis Sanitarium December 1.

Dr. Van Norman's Assistant Appointed.—Dr. K. H. Van Norman, director, Lakeside, Maternity and Babies' Hospitals, Western Reserve University, Cleveland, announces the appointment of Dr. T. Dwight Sloan as his associate, Dr. Sloan's particular work being the administration of Lakeside Hospital. Dr. Sloan is known to many readers of THE MODERN HOSPITAL because of his work in hospital administration in China, where recently he was the medical superintendent of Peking Union Medical College Hospital, Peking.

Pennsylvania

To Direct West Mountain Sanatorium.—Dr. John W. Leckie, Hazleton, has been appointed medical director of the new \$450,000 West Mountain Sanatorium, Scranton, recently opened.

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THE steadily increasing use of intravenous solutions has led us to develop the short bevel Kenwood Hypodermic needle shown above, in addition to a long point beveled needle for subcutaneous and intramuscular work shown below.

The use of the short bevel needle guards the operator against running entirely through the vein, while the long point needle is so constructed that it will cut a clean incision instead of tearing through the tissue.

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Kenwood Hypodermic needles come in a full range of gauges and lengths, and at a cost no greater than the ordinary nickel plated needles. Send for a trial order.

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Auxiliary Pledges \$5,000.—The initial contribution toward the \$150,000 drive to be conducted by the Connellsville Hospital Association was the pledge of the woman's auxiliary to raise \$5,000.

S. D. Hunter to be Hospital Head.—Samuel D. Hunter, formerly assistant superintendent of the Memorial Hospital, Johnstown, has accepted the position of superintendent of the new hospital in Washington.

Bequest to Mason Memorial Hospital.—The sum of \$6,000 with which to endow a room at the new Lewes A. Mason Memorial Hospital, West Chester, is provided under the will of the late Elma Hoopes, East Bradford township.

Endows Room for School Teachers.—The late Simon Gratz, formerly president, board of education, Philadelphia, set aside in his will \$50,000 to establish a private room in Jefferson Hospital for the use of school teachers free of charge. He also bequeathed to the trustees of the hospital \$7,000 to be awarded to the graduate who is adjudged to have done the most in the advancement of medical and surgical treatment of disease or research work within five years after graduation.

Rhode Island

Mirian Hospital Opens.—The Mirian Hospital, Providence, was formally dedicated November 15.

South Carolina

Two New Superintendents Named.—Miss Anna Belle Dean was named superintendent of the Anderson County Hospital, Anderson, and Dr. James B. Beeler was elected superintendent of the Spartansburg General Hospital, Spartansburg.

Celebrates Anniversary by Birthday Party.—The fifth anniversary of the Mercy Hospital, Charleston, was celebrated by a birthday party for the 1,075 babies born in the hospital. The hospital is a fifteen room woman's hospital made possible by the philanthropy of a Charleston citizen.

Tennessee

Dr. R. L. Maloney Purchases Infirmary.—Dr. Robert Lee Maloney, formerly superintendent of the McMinville Infirmary, McMinville, has recently purchased the infirmary and will continue to operate the institution.

Name Heads for New Vanderbilt University Hospital.—Clarence Connell, Nashville, has been appointed superintendent of the new Vanderbilt University Hospital, Nashville, which was recently opened. Miss Augusta M. Mathieu has been appointed assistant superintendent. Miss Mathieu was formerly superintendent of the Washington University Hospital Dispensary, St. Louis, Mo.

Texas

Quanah Hospitals to Consolidate.—The Quanah and the Ball Hospital, Wichita Falls, have announced plans for consolidation of the hospitals and the building of additions and installation of equipment.

Denton's Hospital Opened.—The new hospital at Denton was recently opened and is under the superintendence of Dr. M. L. Hutcheson. The institution is owned by Drs. Ponton and Buckner, Fort Worth.

Memorial Hospital for Corpus Christi.—The sketches have been prepared for the Robert Memorial Hospital, Corpus Christi. The building will be two stories high and will cost approximately \$40,000.

Dr. Johnson Accepts Superintendency At San Antonio.—Dr. W. J. Johnson, who has completed ten years of special institutional work, recently accepted the superintendency of the San Antonio State Hospital, San Antonio.

Keeping X-Rays isolated

IT is not uncommon for unused plates, stored outside the X-Ray room for safe-keeping, to be exposed by stray rays.

Aside from the monetary loss and the inconvenience involved, such an occurrence emphasizes the importance of keeping X-Rays isolated by some means which will protect those who live or work in quarters adjacent to the X-Ray room.

In the hospital, in the office building, in the doctor's home, X-Rays can be kept completely isolated by coating the walls, ceiling and floor of X-Ray rooms with barium sulphate plaster—a new and relatively inexpensive method of X-Ray protection.

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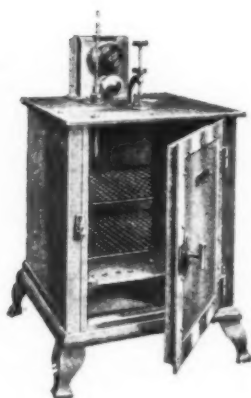
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As district distributors for the Freas and Thelco products we carry in stock a large assortment of different types of both the Thelco and Freas lines, and are prepared to make prompt shipment.

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The spout which formerly protruded from the side is now a small plug hung neatly from a chain attached to the handle. The two handles drop closely to the sides when not in use. The knob on the top is sunk so as to permit stacking one on top of the other without interference.

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*With All Sincerity
Our Greetings and Best Wishes
For You This New Year*

Three Thousand Attend Opening of Medical Arts Hospital.—More than three thousand persons attended the formal opening of the Medical Arts Emergency Hospital, Dallas, held November 16. The hospital is a private emergency hospital owned by Dr. C. C. Holder, superintendent.

Children's Hospital for Dallas.—A movement to establish a children's hospital in Dallas was given impetus recently at a meeting of twenty-five or thirty prominent doctors and citizens of the city who made plans for a fifty-bed hospital to be located, perhaps, in the rear of the Richmond Freeman Memorial Building.

Virginia

Cornerstone Laid for Danville Memorial Hospital.—The cornerstone of the new \$400,000 Memorial Hospital, Danville, made possible through a bequest of a quarter of a million dollars by the late John E. Hughes, tobacco merchant, was recently laid.

Dr. Schools in Charge of Tuberculosis Hospital.—Dr. P. E. Schools, physician in attendance, Pine Camp, Richmond's municipal tuberculosis hospital, has been appointed head of the hospital.

Musical Benefit for Northampton-Accomack Hospital.—"Melody Land," the second annual musical benefit for the Northampton-Accomack Hospital, Onancock, was staged November 18, 19 and 20, by the Accomack County Auxiliary.

Washington

In Charge of Northern Pacific Hospital.—Dr. R. H. Beach has been appointed in charge of the Northern Pacific Hospital, Missoula.

Detention Hospital Abandoned.—The Seattle Detention Hospital for the treatment of women has been abandoned upon the recommendation of the health commissioner.

Northwest Hospital Association Meets.—The Northwest Hospital Association, composed of the hospital representatives from Washington, Oregon and Idaho, met at the Olympic Hotel, Seattle, November 16, under the presidency of C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma. Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, who was en route to New Zealand, presided at the standardization session.

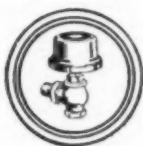
Wisconsin

Marquette Plans New University Hospital.—A popular subscription campaign for \$1,500,000 for a new Marquette University hospital is to be launched in the near future, according to an announcement from the Rev. A. C. Fox, president of the university. The new building is to be located at the southeast corner of Sixteenth Street and Grand Ave., Milwaukee, and will be part of the Marquette health center.

Foreign

Lister Ward Rebuilt.—The ward at the Glasgow Infirmary, Glasgow, Scotland, in which Joseph Lister did much of his early work in antiseptics and which was dismantled a year ago, has been purchased by the firm of Burroughs Wellcome and will be re-erected in London.

Annual Dinner at St. Bartholomew's.—The annual old students' dinner of St. Bartholomew's Hospital, London, was recently held. Plans have been drawn for the rebuilding of the hospital, which provides for more than 700 beds, in the present site and for a pay-patients' block with about eighty beds. The historic Great Hall, eight hundred years' old, will be left undisturbed.



The Modern Hospital Improved

RELYING solely on the thermometer for the properly required temperature indication and guidance of each individual hospital room and the corridors is not sufficiently practical in the modern conduct of hospitals. Thermostat control on the radiator of each room and corridor, as provided by The Johnson System of Temperature and Humidity Control is the essentially accurate means. Overheating some rooms or whole parts of the hospital because of the high temperature requirement of other rooms or section is obviated. Excess fuel consumption is avoided; and 15 to 35 per cent of fuel ordinarily used is saved. For the temperature regulating improvement and the great fuel economy reason install The Johnson System of Temperature and Humidity Control. Many hospitals have done so. Their names and what they interestingly say will be gladly furnished on request.

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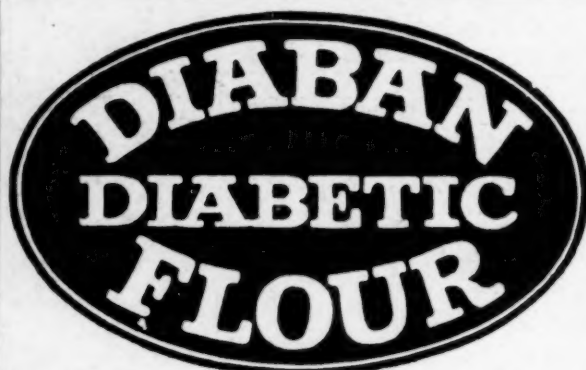
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Sample with recipes sent upon request to any hospital.

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Trade News and Publications

H. H. Chaffee in Charge of Western Office.—H. H. Chaffee has been appointed manager of the Los Angeles office of the Imperial Brass Manufacturing Company's plumbing products. The Los Angeles office is at 1234 South Broadway and the San Francisco office is at 741 Call Building, and is in charge of L. C. Combs.

Hughes Elected Secretary-Treasurer.—D. W. Hughes who, for the past year has been secretary of the Elevator Supplies Company, Inc., Hoboken, N. J., was recently elected to the board of directors of that concern, to succeed the late Henry Herman as treasurer.

Nursery Name Necklace.—J. A. Deknatel & Son, Inc., Queen's Village, Long Island, N. Y., has recently issued a booklet describing its necklace for identification of babies.

New Building for Victor X-ray Corporation.—The current issue of "Service Suggestions," published by the Victor X-Ray Corporation, Chicago, features its new five-story building adjoining the main building at Jackson Boulevard and Robey St., Chicago.

Opens San Francisco Office.—The National Marking Machine Co. has opened its San Francisco office at 837 Howard St., in charge of Edward G. Welage.

Henrici Washer Leaflet.—The Henrici Laundry Machine Co., Boston, has circulated a leaflet describing and illustrating its washers and other laundry equipment.

Booklet Commemorating Fiftieth Anniversary.—The Holtzer-Cabot Electric Company, Boston, published a book recently commemorating its fiftieth anniversary.

Six Floor Tile Pattern Sheet.—A sample sheet of six patterns of floor tile designs has been circulated by the Bonded Floors Company, Philadelphia.

The Octagon.—The November issue of the Octagon, published by the American Steel Foundries, Chicago, in the interest of their employees, has recently been received.

Factory News.—Factory News, published monthly by the Yellow Truck and Coach Company, Chicago, which deals with information of interest to the employees of the company, has been recently received.

The Hobartizer.—A recent issue of the Hobartizer, published by the Hobart Manufacturing Company, Troy, Ohio, has been received. It includes an article and illustration dealing with the American Hospital Association convention at Louisville.

Oriole and Vulcan Bulletins Merge.—Beginning with the November issue, the Bulletins of Oriole and Vulcan Divisions of the Standard Gas Equipment Corporation, New York, merged and are now being issued as the *Bulletin* of the corporation. The merger allows a larger publication, with more sales and merchandising ideas, suggested display and newspaper advertisements and a question box page included.

"How Tumblers Are Made."—Hazel-Atlas Glass Company, Wheeling, W. Va., has recently issued a booklet describing a journey through their tumbler factory, explaining the processes in glass manufacture.